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JOSEPH HIRSH

Methods and fashions of suicide

Part 2

PART 2: METHODS AND FASHIONS OF SUICIDE

The agents and methods of suicide have received relatively little attention by serious students of this subject. They have been regarded almost as incidental—and at that, mechanical rather than dynamic—factors in the process of self-destruction. Yet it is entirely possible that the method might provide a real clue to the motive and process of suiciding. This certainly appears to be a possibility in those who seem to punish themselves for their act by suiciding in a most painful or mutilating manner. The method of suicide might be selected, on the other hand, to serve the function of punishing someone else. There are, of course, many other possibilities.

Are the agents and methods of suicides correlatable with age, sex, religious, occupational, racial and social groups? Are there typically masculine or typically feminine methods of self-destruction? Do youngsters kill themselves in certain charac-

teristic ways and their elders in certain other ways? What determines the selection? Is it chance, personality, time, place, culture or just what? Is there a fashion and fashionability to suiciding?

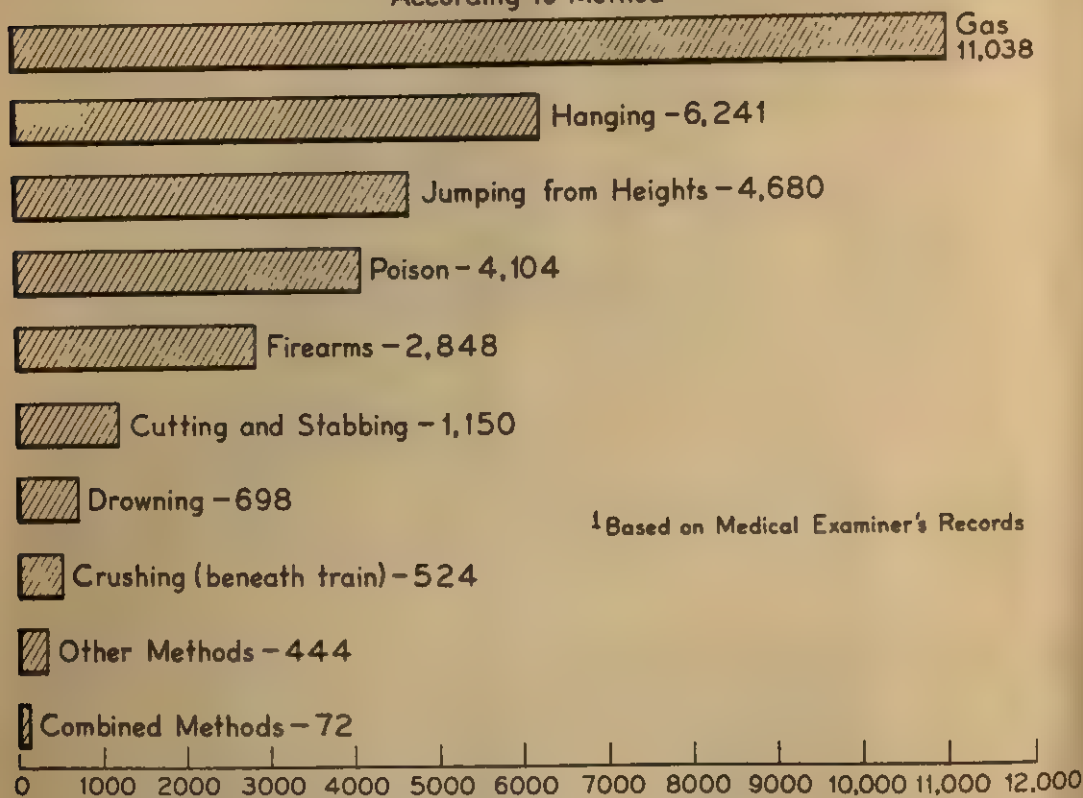
The answers to such questions might offer not only a clue to the dynamics of suicide but would undoubtedly be of practical value in programs of prevention and control.

Actually, what can be said of the agents and methods of suicide? A few broadly stated principles have emerged from observations to date. Though the observation is not supported by the data from the

Dr. Hirsh is associate professor of preventive and environmental medicine at the Albert Einstein College of Medicine, Yeshiva University, New York. Part 1 of his 4-part study of suicide appeared in the October, 1959 issue of *Mental Hygiene*; Parts 3 and 4 will appear in future issues.

CHART 1

TOTAL NUMBER OF SUICIDES IN THE CITY OF NEW YORK¹ (1925-54)
According to Method



City of New York (see Chart 1), it has been noted that many suicidal acts are multiple in method. It's as if the suicide believes that a good thing can be made better by doubling, tripling or quadrupling the dosage or that if one lethal agent can insure death two or three will make you deader. Intelligence, knowledge, professional know-how and levels of sophistication have little or nothing to do with the case.

A physician who knew better triply guaranteed his death by an injection of morphine, ingesting curare and infusing a continuous intravenous drip of sodium pentathol—any of which individually would

have been lethal! Ingesting poison and jumping from a window, a bridge or a ship is another common pattern. The epitome of multiple methods of suicide, however, is described by the New York City Medical Examiners group in their classic text on legal medicine (1). Rube Goldberg-like, the would-be suicide inflicted repeated scalp wounds and cut his throat. Apparently bleeding too slowly, he slipped a noose around his neck and hanged himself from an overhead gas pipe which broke. Autopsy revealed that death had ensued from illuminating gas poisoning!

Children and elderly people who suicide often do not view their act as a terminal

TABLE 1

*Methods of suiciding in the United States, by age and sex, 1954*¹

METHOD	NUMBER OF DEATHS					
	Total	10-14 Years		Total	15-19 Years	
		Male	Female		Male	Female
Poisoning	6	4	2	63	30	33
Hanging and strangulation	19	17	2	46	43	3
Firearms and explosives	12	9	3	133	108	25
Other				19	10	9
Total	37	30	7	261	191	70

¹ From *Vital Statistics of the U. S.*, Vol. II, 1954.

one. Rather, they view it as a process—of punishment, of gaining love and affection or of relieving pain. And their methods of suiciding are often similar. As has been pointed out elsewhere, “a good many elderly people—as if living out a second childhood—express in suicide the violence of children who when rejected, unloved or traumatized by loss of loved ones behave violently. Thus they tend to make their death as shocking as possible. They pitch themselves out of windows of tall buildings or jump from bridges or cliffs; they drown; they hang themselves; they throw themselves in front of moving trains or trucks” (2).

Methods of suiciding in children are essentially action methods. There do seem to be, however, masculine and feminine trends in children just as there are in adults (see Table 1). The most frequent tool for both sexes is firearms and explosives; the chief means for boys is hanging and strangulation but for girls is poisoning.

If the elimination of current, regional or topical pain is the immediate goal, this may express itself in the use of a gun to commit suicide. Such suicides shoot themselves in the temples of the forehead and temples, the sites where headache pain is

felt most keenly. People who are “all tied up in knots,” viscerally speaking, attempt to relieve this immediate pain, as well as the total pain, by opening their chest or abdominal cavities. The impression, which is yet to be supported statistically, is that women in the third, fourth and fifth decades of life who commit suicide often tend to use stabbing weapons. Many of these women, it is discovered, have had menstrual or menopausal difficulties, problems relating to pregnancy, child-bearing or childbirth, unsuccessful marriages or love affairs, or other psychosexual difficulties.

While it is yet to be determined from current studies of a large body of data for the city of New York whether there are characteristically feminine and masculine methods of suicide, the findings from far fewer cases in London, a city of similar size, suggest that there may be sex-typical patterns (see Table 2). Women appear to employ asphyxiation with gas and poisoning—methods of suiciding which involve an important factor—time—or allowing for rescue efforts and resuscitation. Male methods generally do not leave any margin for error, involving, as they often do, patterns of violence.

Actually there has been little change in

TABLE 2

*Percentage incidence of suicide method employed
by males and females in 355 cases **

	TOTAL	MALE	FEMALE
Carbon monoxide	40.6	40.3	41.0
Poison	20.6	16.7	27.9
Jumping from building	12.1	10.3	15.6
Drowning	8.1	9.0	6.5
Hanging	7.9	10.3	3.3
Cutting (throat, wrists, etc.)	5.0	6.4	2.5
Crushing (beneath train)	3.1	3.9	1.6
Firearms	2.0	2.6	0.8
Setting fire to self	0.3	—	0.8
Electrocution	0.3	0.5	—
	100.0	100.0	100.0

* From *Suicide in London: An Ecological Study* by Peter Sainsbury, New York, Basic Books Inc., 1956.

the fashions of suiciding over the centuries. The basic methods involve the use of cutting and stabbing instruments, guns, crushing as a consequence of leaping from a height or beneath a vehicle, various methods of traumatic asphyxiation and poisons. The statistical breakdown of these methods among some 32,000 suicides in New York City is shown in Chart 1.

The most common site of cutting wounds is the throat. The individual generally holds the weapon in his right hand and starts the incision on the left side, drawing the blade to the right. If left-handed, he may incise the right side of his neck, drawing the blade forward and downward. A characteristic pattern of suicidal wounds of the neck shows repeated "hesitation marks," suggesting a consciousness of pain or fear before the final slash is made.

In cases of ineffective self-inflicted wounds of the throat, slashes may be found on other parts of the body, particularly the wrists. Cutting suicidal wounds of

other parts of the body may involve, in addition to the wrists, the inner surface of the thighs and, less frequently in our culture—as distinguished from the Japanese—of the abdomen. There are, however, a number of cases on record of partial or complete self-eviscerations in the United States.

The most frequent site of suicidal stabblings is the chest, over the heart region. Usually the individual grasps the knife in his right hand and directs it upward and to the right into the cardiac region of the left side of the chest. Often this is accomplished with one stroke, in which event the knife is frequently found sticking in the wound. Often there is a pattern of wounds in the chest, indicating a number of jabblings, variable in depth and superficial in character, suggesting hesitation. These are comparable to the so-called "hesitation marks" of cutting suicidal attempts.

One curious characteristic of the stab-

bing suicide, whether he stabs himself once or more times, is the fact that he rarely, if ever, stabs himself through clothing. He will open his outer garments and lift his undergarments before thrusting the suicidal weapon home, as if the clothing might act as protective armor plate.

Another common characteristic of stabbing suicides is that the stabbing effort is frequently only one of several in the final act. The suicide will stab himself and, if he is still ambulant, throw himself from a height or into a body of water, or ingest a toxic substance.

Approximately 115 suicidal shootings take place in New York City each year. These comprise 10% of the annual suicides in the city. Their most common site is the right temporal region if the individual is right-handed, the left temporal region if he is left-handed. The middle of the forehead is another popular site. Occasionally the gun may be placed in the mouth, the nose, the ear, variously on the face or under the chin, pointing upward into the brain case.

Gunshot suicides often are grimly bizarre. Take, for example, the suicide who in the act of shooting himself behaves as if he wishes to protect himself from the projectile. Thus he places his hand between the gun and the site of the imminent head wound. As if through design rather than anatomical ignorance, gunshot suicides rarely, if ever, use the military *coup de grace*, a shot generally in the area of the mastoid process.

Bullet wounds of the chest and abdomen are less common than those of the head. Chest wounds are generally concentrated around the cardiac area, but often require multiple attempts because of imperfect anatomical knowledge. Abdominal wounds are generally inflicted in the epigastric region. Here too multiple wounds are in-

flicted in order to achieve the desired end.

Multiple wounds may involve a single region—temple, chest or abdomen—or a combination of regions where the attempt has been unsuccessful.

Rifles and shotguns are rarely used as suicidal weapons because of their long axis and the inconvenience of positioning them properly in order to achieve the desired end. In suicidal attempts these weapons are generally placed in the mouth, against the front or side of the head, or against the chest or upper abdomen. A recent 4-year study of 167 shotgun deaths by the Maryland assistant state medical examiner showed that 91 were suicides, 57 homicides and 17 accidental. Apparently shotgun fatalities are far more purposive than newspaper reports suggest.

In suicides there are two basic forms of strangulation—by hanging and by ligature (garroting); the latter is far the less frequent form. In hanging, strangulation is achieved by the application of a noose, strap, band or other external mechanism around the neck which is tightened by the weight of the body, thus closing the air passages. Contrary to popular opinion, except in cases of legal hanging death rarely ensues as a result of a broken neck. What generally happens is a simple, mechanical realignment of certain anatomical features of the neck resulting in occlusion of the lumen of the upper portion of the larynx. But there are other factors, notably simultaneous interference with cerebral circulation, thus resulting in almost immediate loss of consciousness and shock once hanging starts. As a consequence, the suicide-to-be, if he has a change of heart, rarely can reverse the process.

There is no one method of hanging. The various methods are based on the simple principle of effecting sufficient traction by the exertion of body weight to

close the airway. This can be achieved in a standing, sitting, kneeling or even in a prone or supine position.

Ligature or garroting is a method of strangulation by which the constricting band is tightened other than by body weight. Most of such strangulations are homicidal; occasionally, however, they are suicidal. The victim actually strangles himself!

Suffocation is that form of traumatic asphyxiation resulting from an obstruction of the airways. This may be achieved by smothering and choking. Smothering occurs when external openings of the airways—the nose and mouth or the laryngeal opening—are occluded by a solid object or finely-divided material. Most fatal smotherings are accidental but occasionally some are suicidal. Among the bizarre suicidal methods used are tying a pillow over the face, strapping broad adhesive tape over the nose and mouth and cramming a bath towel down the mouth. Each of these methods described by Gonzales, Vance, Helpen and Umberger (1) appear to be sex-specific, involving women. Apparently smothering is not a male suicide's method of choice.

Drowning is a form of suffocation occurring when the victim's air passages are blocked by water or other fluid. The cause of death in 90% of drownings is asphyxia resulting from the inhalation of water into the lungs and exclusion of air. A small percentage of deaths occur during submersion as a result of circulatory collapse or syncope.

Drowning is neither a simple, easy or rapid way of doing away with one's self. The process varies, may be extremely unpleasant and may take from 3 to 10 minutes to complete.

One psychological characteristic more typical of drowning suicides than many

other suicides is the fact that they tend to leave so-called suicide notes. During drowning, suicides display a variety of patterns. Some die of shock, almost immediately. These are the syncope victims. The asphyxial types generally go through these stages: inhalation of water at the moment of submersion, panic, reflex spasm of larynx, gulping of water and air, severe coughing and expiratory efforts, more water is inhaled and swallowed, vomiting takes place, respiratory movements become violent, face becomes cyanotic, bladder and rectum empty. Unconsciousness and asphyxia ensue. After respiration ceases the heart may continue to beat for a short time.

Suicidal drownings in New York City average 30 a year or 3% of the total number of annual suicides. Oddly, some of these suicides tie their legs together but leave the arms free, as if to make ultimate escape possible if there's a change of heart, take poison orally or inflict stabbing or cutting wounds beforehand, or jump from a height—a bridge, for example—into the water.

The exhaust fumes from internal combustion engines contain on the average 7% of carbon monoxide, a highly toxic gas. Accidental deaths frequently ensue from running an automobile engine in a confined or closed space, and even occasionally while the car is moving with the windows closed.

Suicidal deaths from carbon monoxide poison are more common than one would suspect (see Table 2). In the past when gas illumination and gas cooking were features of our culture, suicide from gas fixtures as well as carbon monoxide poisoning accounted for the largest number of self-inflicted deaths in studies reported on to date (see Chart 1). "To take the pipe," meaning the gas pipe, was an idiom of that era. It followed a pattern: suicide note,

stuffing window and door cracks, detaching the gas tube leading to a fixture and placing it in the mouth or near the nose, holding the head over the stove's gas jets or placing it in the oven. An occasional by-product of such an enterprise was an explosion which resulted in the suicide's neighbors or family involuntarily joining him.

Suicidal burns and electrocutions are rare (see Table I). But as an occasional expression of extreme psychopathy an individual will douse himself with kerosene or some other combustible and ignite himself. As an added fillip, aflame he may throw himself from a height. Rarely he will rig an elaborate electrical apparatus to do himself in but such bizarre techniques are employed generally by psychotics with special skills or professional training.

There is an ancient history attached to the ingestion of poisons for the purpose of committing suicide. Among the most classic of the early historical references involves the ingestion of hemlock by Socrates.

A wide variety of substances are ingested. Many are determined by culture, social status, profession, education and economics. Poor and uneducated people tend to use substances that are inexpensive, readily available and accessible, such as cleaning fluids, insecticides and rodenticides. Educated, sophisticated and better educated people generally turn to the barbiturates.

An example of status or professional determination of the means of suicide is that most commonly found among physicians. They tend to use lethal drugs by ingestion or injection. Occasionally, however, as if to deny their special knowledge or to punish themselves for the act they are about to commit, they will use some of the cruder more painful poisons, or destroy themselves by most primitive means.

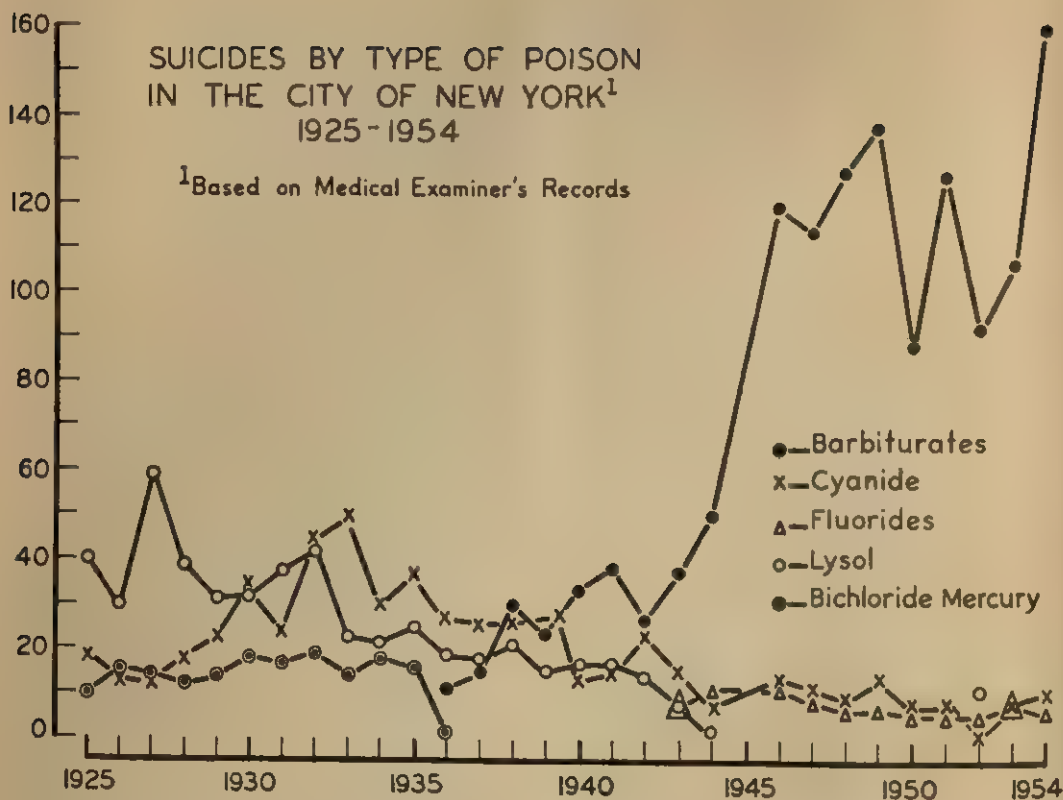
The patterns of poisoning have been

changing in recent years (see Chart 2). The data for New York City reveal the disappearance of bichloride of mercury from the scene by 1936 and of the cresol family such as lysol by 1944. Cyanides and fluorides had a greater fashionability as suicide poisons prior to World War II. They have played a diminishing role ever since. The most dramatic change in suicide poisons is reflected in the widespread use of barbiturates since 1935.

With the advent of the tranquilizers it may be expected that the fashionability of the barbiturates too will have passed. The fabulous story of the tranquilizers is actually less than ten years old, dating back to 1949 when Dr. Robert W. Wilkins, came upon a British medical paper on the use of *rauwolfia* in the treatment hypertension. Within a matter of three years *rauwolfia* and its most important chemical constituent *reserpine* became medical household words in the United States. In 1953 along came the second of the tranquilizers, *chlorpromazine*. This drug, which shortly found wide application in the treatment of mentally disturbed patients, triggered the development of scores of other drugs. By 1956 it was estimated that 1 out of every 7 persons in the U. S. took some form of tranquilizer. By 1957 the Medimetric Institute, a drug market research organization, estimated that 36,000,000 prescriptions for tranquilizing drugs had been filled by druggists the preceding year, and that Americans swallowed 1,250,000,000 tranquilizing pills—the equivalent of 300 tons.

The extreme fashionability of tranquilizers is attested not only by their widespread and ready acceptance by the public and medical profession, by the number of jokes and gags built up around them, by the happy economic reports of the pharmaceutical houses, but also—and somewhat on the grim side—by their increasing popu-

CHART 2



larity as a suicide drug. Just as the barbiturates superseded bichloride of mercury so it is safe to conjecture that the tranquilizers may one day soon replace the barbiturates as an important agent of choice in suicide. Increasingly the literature these days warns of the toxic effects of the tranquilizers, the danger of overdosing, the tragedy of true accidents, and the challenge of purposive accidents in which the drugs are playing a chillingly serious role (3, 4, 5, 6, 7, 8, 9).

No less ironical is the grim use to which another product of our age is being put. Like so many other plastic articles, plastic bags were designed to make life a little easier and pleasanter. But by the spring of 1959 health officials, merchants and

manufacturers were warning parents—who under any circumstances should be alert to the potential hazards implicit in the most innocuous of products once in the hands of children—of the dangers of plastic bags. The warning unfortunately grew out of a disconcertingly large number of accidental deaths due to suffocation in which plastic bags were the agents. Reports of these deaths had hardly been published when they were joined by other, even grimmer reports. They had become, if not a fashionable agent of suicide, sufficiently popular to add to the list of reasons for curtailing their use.

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PAUL HAUN, M.D.

The empty ranks

The preliminary findings of the task force on man power of the Joint Commission on Mental Health and Illness lend a note of authority to the impressions many of us have gathered in recent years. Our community services, our clinics and our hospitals suffer from a shortage of trained professionals due less to local recruitment difficulties than to an absolute shortage of personnel. The situation is complex, and we are indebted to the task force for clarifying many of the unpleasant realities. Broad social factors have affected our economy as a whole. The low birth rate prevailing during the depression years resulted in fewer students entering college during the late 1940's and early 1950's. With

fewer candidates from which to choose, graduate schools have found it difficult to maintain their enrollment, and many have had to reduce their admission requirements.

Enticing opportunities for well-paid employment making little demand on the knowledge or skill of the applicant have siphoned off a great many young men and women who in less prosperous times would have continued their education and in some instances, at least, have entered the mental health professions.

Attempts to capture the interest of the shrinking group of college graduates have been intensified. We have all heard of the blandishments to which the able student is subjected by representatives of business and the professions; of the subtle and not so subtle court paid to professors and heads of departments urging them to steer their promising students into one or another field eagerly promoted by the lobbyist.

To maintain our present teacher-pupil

Dr. Haun, who is director of psychiatric education for the New Jersey Department of Institutions and Agencies, presented this paper June 5, 1959 at the 8th annual meeting of the New Jersey Association for Mental Health.

ratios in primary and secondary schools, one-half of all college graduates for the next ten years would have to become teachers. The educational prospect for our young people is further darkened by the flight of qualified instructors, particularly in mathematics and the physical sciences, into better paid and often less demanding jobs in industry. How successfully our educational system will meet these problems, how well prepared it is to absorb the deluge of war babies now well along in their teens, remain to be seen.

The National Man Power Council offers four indices for recognizing man power shortages: (1) the existence of a demonstrated social need; (2) the appearance of budgeted job vacancies; (3) a rise in salaries; and (4) the presence in jobs of inadequately trained people. In spite of the lag in salaries characteristic of public agencies I think we can agree that every mental health profession meets these criteria.

Approximately 350 trained psychiatrists become available each year to meet the needs of the entire country. Since the majority enter private practice, it is estimated that fewer than 100 individuals enter public institutions and clinics.

For some time social work jobs have been multiplying with such rapidity that the spread between supply and demand has increased rather than narrowed. The prospects for psychology are much the same.

The situation in nursing is a little brighter because the number of nurses being trained is increasing at a more rapid rate than would be expected from the growth in population alone. There is some reason for believing that we can attract a proportionately larger number of these graduates into the field of psychiatric nursing.

Present shortages exist, however, and in all likelihood will continue in other mental

health fields, such as occupational therapy, hospital recreation, counseling and group work.

Dr. Albee, director of the task force on man power, puts it this way: "The blunt facts are simple. We do not have enough trained personnel to handle the demands of our society in the field of mental health, and these demands are growing faster than we are training personnel to meet them."

The studies of his group call attention to the well-recognized fact that mental health personnel tend to gravitate to urban centers, rather than to distribute themselves in accordance with the geographic need. There is also evidence that graduates are disposed to settle in the same general area in which they were trained. The presence of educational and training centers are, accordingly, related to the number of personnel available.

How have we met these problems? What have we done to attract new recruits?

We have followed the lead of industry in a progressive reduction of working hours until today the 40-hour, 5-day week is as much the standard in a mental hospital as in a General Motors plant.

We have patterned our personnel practices after those adopted by Standard Oil, DuPont and other large business enterprises: paid vacations, cumulative sick leave, efficiency ratings, merit promotions, grievance procedures, job security and free insurance.

We have taken a leaf from Madison Avenue and—under the somewhat misleading name of public education—have conducted our advertising campaigns and launched our propaganda barrages. We buy television and radio time or have it given to us; we try to make our pamphlets on service careers as eye-catching and persuasive as possible; we ring an annual bell for mental health.

Recently we have moved into the fields of education and research, where we conduct training programs, issue diplomas, grant scholarships, award stipends and submit protocols in much the same fashion as does any state university or private college.

Lastly, we have adopted, in their entirety, mercantilistic criteria for the establishment of salaries. These impose two essential guidelines. First, we must keep a wary eye on the general economy. What is the going rate for all employment categories at General Dynamics, A. T. & T. and Montgomery Ward? Second, we must meet and, if possible, surpass the scale paid by our competitors in neighboring states.

The pressing question remains whether further shortening of the work week, longer vacations, increased retirement benefits, stepped-up advertising, fatter stipends, more scholarships and still higher salaries will put us on Easy Street. Do we need to do more of what we are already doing? Do we need to do it better? Do we need to do something entirely different?

George Devereux,¹ the sociologist and anthropologist, has recently called attention to the pervasive influence of cultural thought models on the pattern of human life. At each stage in the development of civilization, in the simplest to the most complex society, there are certain ways of thinking, certain value systems and certain fashions of looking at the world and at man which exert an impressive influence on all human institutions and on every living person. A troublesome quality of these interpenetrating models is the profound difficulty we experience in identifying them in our own civilization and the relative ease with which we can see them

in operation in past historical eras and among contemporary peoples whose social organization is radically different from our own.

Perhaps the readiest analogy to our singular position in these matters is to be found in the realm of fashion. In 1929 we walked our streets, worked, traveled, attended meetings and mixed with our fellows in much the same way and with much the same purposes as we do today. Everyone looked natural to us. We looked natural to everyone else. Even those individuals who strove to be fashionable, to be considered the best dressed woman or the best tailored man of the year were in our eyes only more exquisitely gowned or better groomed than the rest. Thirty years later we see the same clothes, the same manner of walking, the same hats, the same use of cosmetics as grotesque or amusing, appropriate for nothing but a masquerade. Will our contemporary fashions appear less odd to us thirty years hence?

The cultural thought models with which we are concerned are at the same time more significant than the whims of fashion and less easy to identify. As with fashions, however, they can be seen most clearly in historical perspective. For example, it is comparatively easy for us to trace the effects of religious faith in Europe during the Middle Ages, to see the great cathedrals as a logical result of belief in a Christian God, the crusades as understandable corollaries, and scholasticism with its absolute reliance on authority as a necessary consequence of ecclesiastical absolutism. It is easy for us to see the rationality of the 18th and 19th centuries as a necessary outcome of the enlightenment; to understand the Utopians' dream of translating into human affairs those principles of observation, logic and experiment which were so astonishingly successful in the physical sciences; to grasp

¹ "Cultural Thought Models in Primitive Theories," *Psychiatry*, 21:4 (November, 1958), 359-374.

the depth of the new faith in the inevitability of progress.

Are there thought models implicit in our contemporary culture of which we are partially or totally unaware? Do these find diverse expression in our value systems, in our rather vague picture of the future, in our somewhat misty ideals and quite concretely in the automatic attitudes we adopt in approaching familiar problems in the field of mental health? I suggest that we have been influenced by one such thought model—the idea of production for profit.

Too much of our material abundance has resulted from this cultural pattern to give us ground for believing that we have entirely escaped its influence. Objectively, the modern world is the direct result of a conviction that by blending in their proper proportions capital investment, machines and technical skill, monetary profits can be earned by making it possible for everyone to own a refrigerator. Profits are the necessary incentive in this transaction since they permit all participants to purchase those material objects that they prize. The validity of this view cannot be challenged. It has worked and its success has surpassed the most optimistic prophesies.

The question, I think, is whether the cultural thought model of production for profit applies to mental health. What desirable product do our hospitals manufacture? Is the primary orientation of our clinic workers necessarily toward profit? Are incentives for the General Electric shop foreman identical with those for a head nurse?

I would in no way disparage the form taken by our conventional efforts at recruitment. I raise no questions as to their relevance and no doubts as to the necessity of our continuing along comparable lines. What I do suggest is that by limiting our

efforts to what are essentially mercantilistic parameters, by accenting only those personal rewards which are *all* that business has to offer, we have neglected (and even at times have forgotten) the lasting attraction of those very things which set us apart from factories, from brokerage houses and from construction companies.

David Riesman² predicts a shaky future for the profit incentive as the prime human motivator in post-industrial civilization. "Even the most confident economists," he writes, "cannot adequately picture a society which could readily stow away the goods likely to descend upon us in the next fifteen years . . . with any really sizable drop in defense expenditures. People who are forced by the recession or by fear of their neighbors' envy or by their own misgivings to postpone for a year the purchase of a new car may discover that a new car every three years instead of two is quite satisfactory. And once they have two cars, a swimming pool and a boat, and summer and winter vacations, what then?"

"In better educated strata the absence of goals for leisure and consumption is beginning, or so I would contend, to make itself felt. In these latter groups it is no longer easy to regard progress simply in terms of 'more'; more money, more free time, more things. There is a search for something more real as the basis for life . . . Such Americans are not satisfied simply to attain material comfort far beyond what their parents possessed . . . In fact, the younger generation of reasonably well-off and well-educated Americans do not seem to me drivingly or basically materialistic; they have little ferocious desire for things for their own sake."

² "Leisure and Work in Post-Industrial Society," in *Mass Leisure*, edited by Eric Larrabee and R. B. Meyersohn (Glencoe, Ill., Free Press, 1958).

Medicine has been from immemorial time one of the three learned professions. The essential and lasting distinction from occupations that are commercial, agricultural or mechanical is that physicians, by training and by personal dedication, are members of a *professional* group. Let me call your attention to the significance of this word. It derives from the Latin *profiteri*, which means to profess, and to profess means to be bound by a vow which is freely taken and openly declared. It means that a faith is asserted and a calling chosen to which one dedicates his life. A profession asks nothing of society but an opportunity to perform its essential function in dignity and in honor. It demands proficiency of its members and imposes its own discipline upon them. Since it is understood that every member will attempt to surpass himself, it awards prestige sparingly to those whose self-imposed standards are the highest. It is the collective conscience of excellence. It does not know and scorns to learn the techniques of bargaining. Its goal has never been production for personal profit, nor can this aim ever become its motivating force. It is the last refuge for those who would dictate only to themselves, whose self-respect demands a purpose which can not be reduced to absurdity, who believe in the ultimate worth of the human spirit.

As a member of the profession of medicine, the physician recognizes one opponent only, one enemy against whom all his battles are fought, all his resources marshalled. That enemy is disease. In this kind of warfare he is obliged at times to match wits with his patient, to deny him what he wants, to rout his fears, to condemn his prejudices, to uproot his settled habits and to chivy him into actions which would never otherwise be taken. It is

the physician's duty to fight—with the patient's cooperation or if necessary without it—against his illness. This is scarcely the kind of intervention any of us would seek without overriding cause. It remains a service without which all of us would be the poorer.

The hospital nurse, the occupational therapist, the recreation worker, the psychologist or the social worker who qualifies for membership in one of the supportive medical professions all share in the immunities and privileges as well as in the obligations and responsibilities that professional status imposes on the physician.

Society has always accorded a highly specialized place to the professional. It goes farther in granting distinctive exemptions and imposing unique obligations on the professional in medicine. There is a clear but unspoken recognition of the nature of this social contract. The doctor is not expected to have either immortality or the certain cure of all disease within his gift. He is expected to be selflessly concerned with all his patients. With this expectation goes the tacit understanding that his medical involvement in the welfare of others leaves him neither the interest nor the energy to advance his own material or social position by the devices open to other men. Society willingly takes over responsibility for such matters.

The persistent viability of these implicit understandings is indicated by the incredulous shock we experienced a few years ago when a tiny group of misguided doctors went on strike against intolerable conditions in a certain state hospital; by our mocking doubts of the professional integrity of the rare physician who becomes independently wealthy through the practice of medicine; by our inability to conceive of a community which would allow "its doctor" to starve.

It is both easy and fashionable to be cynical about these traditions and to point to the venality of individual physicians, just as it has always been easy to single out corrupt politicians, traitorous military leaders and renegade clergymen. The professionals of medicine have no monopoly either on virtue or on vice. Their failure on occasion to measure up to the standards we hold for them is sorry evidence that our expectations are at fault. The frequency with which many surpass in dedication all that we might dream of asking is sufficient basis for the honor we continue to pay their ideals.

It is easy and fashionable to satirize such old-fashioned words as respect and unselfishness, dignity and faith, honor and devotion. We are instructed that every man has his price; that principles are always soluble in gold; that the rungs of the ladder of success are formed by the necks of our competitors. These sour views have currency among those whose emotional wounds are slow to heal, whose need for approval, for acceptance and for love is great. No further exposition of their essential inaccuracy is required than the knowledge that no sane man honestly believes that such principles guide his own conduct.

Our finest minds are sick of cynicism.

The best of our youth is eager for a cause to live for, not a frightened conformity to die within. Each has a vital need to shape the future, to make his personal imprint on the face of time, to wrest a fragment of order from the vast disorder. Not a few are shocked at the educational pressures which in the words of John Unterecker would machine them into well-rounded intellectual billiard balls, compartmentalized, isolated, depersonalized.

It is to this elect that we can and must appeal. It is to those who have seen the feet of Moloch that you and I can and must address ourselves. It is by our convictions and our beliefs, by our spoken thoughts and unspoken attitudes, by our value judgments and our very flippancies that we can remind the eager child, the curious stripling and the impatient youth of an ethical order which puts selfless devotion to mankind above most human endeavors, which respects true dedication and deeply honors those who would serve. Judith Crist has added the matter up with admirable brevity. She puts the inducement quite simply as a "sense of service beyond one's self and a consciousness of craft; in short, professional pride." This is the gauntlet I would throw down before our empty ranks.

Casework treatment of a homosexual acting-out adolescent in a treatment center

In this paper I should like to focus on an adolescent whose primary symptom was homosexual acting-out behavior. The main attempt will be toward demonstrating that casework techniques can be applied in such cases, with encouraging results. In addition, the treatment of this adolescent is within the milieu and controlled setting of a residential treatment center.

Because of the severity and deep-rootedness of the problem, the treatment should be done only under close casework supervision and psychiatric consultation. Con-

ferences between the caseworker, casework supervisor and psychiatrist were held to determine the applicability of casework to this boy.

Because of our limited knowledge in the treatment of sexual deviations such as overt homosexual behavior, we caseworkers approach individuals of this symptomatology with understandable reluctance and hesitancy. Certainly the significance and handling of such a symptom in an adult may differ considerably from that of an adolescent. This is specifically so because such behavior in adolescents is frequently part of the normal adolescent conflict.

We know that with the onset of puberty the adolescent is torn asunder. At this stage of life there is an upsurge of libidinal energy which breaks down the rapport that had temporarily resulted between the ego

Mr. Wasserman is a caseworker at Bellefaire, a regional child care center and service affiliated with the Jewish Children's Bureau of Cleveland. Bellefaire, a residential treatment center for emotionally disturbed children, has a population of 90 to 100 boys and girls from 6 to 18 years old. The therapy is carried on by caseworkers under casework supervision and with psychiatric consultation.

and id (during latency). Impulses (aggressive and sexual), which during latency were brought under balance, at adolescence create an onslaught which overwhelms the ego and superego. The adolescent suddenly indulges in activities which heretofore had been considered taboo and he (or she) begins to resist and rebel against all forms of authority.¹

The adolescent whose behavior is manifested by the symptom of homosexual acting-out presents a unique problem. It is at this period of life that the adolescent is seeking identifications. Frequently the young person forms an attachment to another of his or her own sex and age which takes on the form of passionate friendship and love. Because of the pressing conflict of instincts, the attachment may be expressed by overt homosexual behavior. It is therefore difficult to determine at what point the adolescent is forming a homosexual, pathological adjustment which may become a fixed pattern and perhaps be irreversible, and what is merely the "temporary" acting-out which will gradually be replaced by stronger inner controls and defenses.

In working with this particular adolescent boy, it became extremely important that the psychiatric recommendations and suggestions be such that they could be implemented by casework technique and the environment. Because the homosexual problem in this case had become a conscious matter to the youngster, the casework treatment needed to be geared to reality and ego support. The amount of ego needed to be determined as well as the degree of reality assessment and inner anxiety. Sublimating outlets for the aggressive and sexual impulses and activities that would be supportive and stimulating to the ego had to be provided by the environment.

This is the case of A, a tall, sandy-haired, green-eyed, sharp-featured, bright, handsome young man of 19 with a well-built body of almost classic proportions. He was placed at the treatment center when he had just turned 14 years old. At the time, he appeared older than his age owing to his almost mature-looking build, his outward poise and politeness and his well-dressed appearance.

He is the eldest of three boys and one girl, his brothers being four and a half and six years younger, his sister seven years younger. He comes from a mixed marriage; his father is Jewish, his mother Gentile.

Since the age of five (according to the parents) A presented problems. He lied and stole, and was uncooperative in any routines such as eating, washing, family rules, etc. For periods of time he was enuretic. In general, he was very immature, even infantile, and tended to isolate himself from both peers and adults. Occasionally he was extremely provocative to younger boys and sought out opportunities to beat them up. In spite of superior intelligence, he did poorly in school, failing in several subjects and receiving gratuitous D's in others.

A severe and hostile atmosphere existed between A and his mother, who was controlling, aggressive, ambitious and competitive with him. She had a strong need to mold him into a submissive, polite boy. The marital situation was a poor one in that the husband was most passive and reluctant to assume a more assertive role as husband and father. He worked in a factory and was consistently reminded by his wife of his inadequacy as a successful breadwinner. In all, the role of disciplin-

¹ Anna Freud, *The Ego and Mechanisms of Defense*, 158-70.

ing the children was left to the mother, which was undoubtedly overwhelming and frustrating for her. A had particular difficulty with his next younger brother C, whom he described as always being favored by his parents, particularly his mother. A seemed almost indifferent to his other siblings.

As his behavior progressively deteriorated, it became of extreme necessity to remove him from the rejecting, tense environment of the home. On his arrival at the treatment center he made a most promising, appealing, initial impression, but underneath the clean-cut, wholesome look was a deeply angry, damaged, frightened, sensitive, unloved child who had, in a large sense, given up on himself.

In brief form this, then, is the history of A and some of the presenting problems. It did not take long to observe that the pleasant, seeming outgoingness of this boy was superficial—and he didn't allow relationships to develop beyond the superficial. During the first six months of casework interviews, A handled all reality discussion by flights into fantasy. He insisted on talking about jet guns, model rockets and "super bathyspheres." He denied any reason for being at the treatment center except difficulty in school and escaped all discussions as to feelings around placement and separation from home.

During this period, it was decided through supervision, psychiatric consultation and a staff planning conference that the caseworker should hold up reality whenever possible. It was felt important that in order to reach this boy the caseworker should talk at some length with him about rockets, jet guns, etc., and of his plans to construct such projects. The psychiatric thinking, at the time, was that such inventions might be a projection of

himself and the telling of these inventions to his caseworker might be his way of wanting the worker to be his friend. Talking to A about rockets and guns was seen as a means of establishing a relationship with A and of breaking through his defense of being totally self-reliant, independent and self-sustaining. By so doing, we hoped that A's feelings would then come to the fore and the desire for a relationship would take hold.

At the end of the first six months there was the first discovered incident of A's engaging in homosexual play with one of the younger boys of another cottage. This was then followed by A's first admission that he "hated" the center. His homosexual acting-out with younger boys increased. When confronted with this by cottage personnel and the caseworker, he was vigorous and hostile in his denial. With the emergence of this acting-out came increased overt hostility along with frequent withdrawal and isolation. However, there was a decrease of fantasizing, especially with the adults in the cottage, and as he gave up the fantasizing, the overt homosexual behavior continued. Throughout the first year of casework contacts, A's defenses seemed to be primarily projection and denial manifested by flights into fantasy. He was also suspicious, and frequently accused others of spying on him.

Throughout that fall he developed a strong, homosexual attachment to a 12-year-old boy. A freely admitted that he "loved" the boy very much, "more than he ever loved" his parents or brother. At this time it became necessary to set up extra controls and supervision for A to protect him as well as the other boys. He was not allowed in the younger boys' cottages (unless accompanied by an adult) and he could not invite them up to his room. The group contagion of the prob-

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lem, because of the normal existence near the surface of such feelings in adolescents, can present considerable difficulties in maintaining outer controls and limiting the acting-out whenever possible.

The previous summer, I had worked as a counselor with A in his cottage. By the end of the summer he had told me of his homosexual feeling toward the 12-year-old boy to whom he had such a strong attachment. In the fall when I returned to the center as a caseworker (A's worker was leaving) A was assigned to me.

In his first interviews with me he referred back to the previous summer when he admitted his homosexual problem to me. I accepted what he said but did little or no exploring except to underline that this was a problem and that he seemed worried. Over a series of interviews he admitted his concern more and more and began to bring out that he feared he could not control his acting-out. This admission came after I took a definite stand to the effect that having and talking out these feelings was all right but that acting them out was unacceptable. This became the theme of our contacts for about six months.

During this period, on the basis of the presenting material the psychiatrist pointed out that A could be treated only if he felt more anxiety. This caution was based on the fact that A was acting-out and showing little concern about his behavior. The acting-out interfered with treatment and it would have to be brought under control before he could be reached. The lack of anxiety, it was stressed, made treatment of such overt behavior unpromising. However, it was decided that I continue to try to stir up his anxiety by pointing up his behavior as unacceptable and by telling him that he was expected to learn to control it. The need to hold up reality to him and to support his weak ego whenever

possible was stressed by the psychiatrist.

With the implementation of these suggestions and direction, A became noticeably anxious. He began to hide his face, when talking to me, shielding his eyes with his fingers and looking down at his feet. He spoke of how "ashamed" he was and said he would "rather be dead" than talk of his homosexual feelings. I had to assure him that talking was right. When he spoke of his fear that he would not be able to control his feelings, I was reassuring but firm. I let him know these feelings were rough on him but said he was expected to learn to control them; this was what society and the center expected of him. Furthermore, I told him he didn't help himself by acting-out as he involved another person, and this was serious. I underscored my concern for him. His behavior could only bring trouble and hurt and unhappiness. He had been hurt and unhappy enough.

With this kind of empathizing, A slowly started to bring out his negative feelings toward his parents, particularly his mother. He felt his parents did things wrong and said he couldn't stand it when his mother yelled and screamed at him. He recalled the constant arguments in the home and said he was always fighting with his mother, sometimes with his father, and practically all the time with his brother. He brought out that his parents had often sent him away. He recalled that when his brother C was born he was sent to an institution for six weeks. He was mistreated there and, according to him, his parents didn't seem concerned. He felt he had been tricked into coming to our center. He had thought he was coming to a "glamorous" setup and had not been told that this was an institution for emotionally disturbed children. He hated his parents for sending him here. It seemed to him that the

only children who came here were those who were "useless and whom nobody wanted." He wondered if "this is really life?"

By that winter A began being extremely hostile to me. One day after I had watched a basketball game at the center's gym, in which A participated, he came for his appointment and blasted me. I was "spying" on him. He didn't want me ever to come to the gym again. When he calmed down he was able to admit that seeing me outside the office was upsetting to him. In the next moment he exploded and insisted that I was "not curing" him. The only reason he was coming for his interviews was to let me know how much he hated me.

Concurrent with these expressions of intense hostility toward me, there were rather dramatic changes in the cottage. A became an active participant in group activities and was thoroughly enjoying the participation. He began to stay with the group and to take on a leadership role. The boys showed a real respect for what he had to say and offer, and his ideas started to be "picked up." He appeared to be more genuine and friendly. Most of all, there were fewer and fewer incidents of overt homosexual behavior. Though his sexual behavior was better controlled, he was most stimulated in the evenings when the boys took showers. He would wait until all showers were taken and then he would sneak into the bathroom. If sexually aroused when accidentally seeing a boy in the nude, he would start to yell, have a temper tantrum, and then bring himself under control.

In his casework interviews, his hostility, after about six months, began to lessen. He spoke of feeling better and talked about being in a "neutral zone," of not feeling sexually attracted to either boys or girls.

For the first time he recognized that he was being helped, and the tone of his conversations began to change from "I can't be helped" to "I have been helped." At one point he said: "When I came here, I knew right from wrong but it made no difference to me, for I had no past and I didn't feel I had a future. Now I can look at my past a little bit and I feel I have a future. I was like a little boy in a big world and I felt very lost."

After two and a half years of failures and marginal work in school, A completed junior high school with D's and some C's. His greatest difficulties were in concentrating, in his short attention span and in continually daydreaming. However, the first signs of a freer, spontaneous manner appeared and there were the beginnings of achievement.

Late the following summer A was seen by the psychiatrist (in order to verify casework impressions). It was felt that he was showing better control of his sexual problems. He refused to discuss his sexual problems with the psychiatrist, which was indicative of having built up some defenses around this. He related on reality subjects, which suggested increased ego strength. The psychiatrist felt I should allow A to talk about his homosexual problem as much as he wanted.

Around that period, A was also re-tested by the psychologist. Two and a half years before his tests revealed a picture of a boy functioning intellectually in the bright normal range (full scale IQ 114). Now his intellectual level was in the superior range (full scale IQ 121). Two and a half years before he resisted any forms of self-expression by maintaining a rigid guard and refusing to expose himself. Now he was still somewhat restricted but he showed a remarkable change in the freedom and spontaneity of expression within the bounds

he had set up. He showed a neurotic type of adjustment but more social awareness.

For the next six months however, A seldom spoke of his homosexual feelings except to say that from time to time he got aroused and anxious. But he was able to keep these feelings under control. With the internalization of his anxieties and the controlling of his acting-out, he showed more concern about his physical health. Through most of his interviews, he kept telling me that his heart was beating too fast and that he feared it would stop or that "a bubble or something like it" was trying to pass through his heart.

As he spoke of his life, he said: "What can I do? I can't live with my parents. I have no future, my life is ruined, there is no one to love and if I can't love my parents, there's no one." I acknowledged his concern around this and also pointed out how far he had come, particularly in showing better control of his behavior.

With the lessening of verbalization of his homosexual feelings and the revealing of increased inner controls, the diagnostic picture changed. It had been about a year and a half since the psychiatrist had indicated that A could be treated only if his anxiety became apparent and that this could occur if his acting-out could be brought under control. Now homosexuality was seen as a neurotic symptom; the boy would require intensive treatment. The psychiatrist suggested that I point out to A that he could talk to me about his sexual problems but that he might someday need more intensive help from a psychiatrist. He felt it important that I point out to A those goals and areas in which I could be of help to him. A's signs of increasing ego strengths, according to the psychiatrist, made the prognosis more favorable.

At the same time, in supervisory confer-

ences, it was felt important that I help A to see his parents more realistically, to see that they were confused and unhappy. I might point out that as a child he couldn't help reacting the way he did—with anger. It was important, however, that he realize he had his own life, that though he couldn't change the past he had a responsibility to himself about the future. We needed to help him develop a concept of self and to recognize himself as separate from his parents. The symbiotic and seductive relationship with his mother could be countered by helping him to see his separateness and to see that what he wanted and did with his life rested with him.

In the months that followed I began to initiate and implement the plan that evolved in the shared thinking of the psychiatrist, supervisor, staff conferences and myself. By the following winter A was letting me know that I wasn't "giving him enough." He kept expressing the wish that I were a psychiatrist, and spent much of his appointment time wanting to know why I didn't become a psychiatrist. He informed me that he was still occasionally bothered with his feelings toward boys but said he could control them, adding that sometimes he didn't even have to think about controlling them—"it just comes natural."

Around that time he showed a strong interest in hypnosis and insisted he was going to hypnotize other boys on campus. I was definite in stating that hypnotizing other boys was very serious and was prohibited. A exploded, demanding that I allow him to hypnotize others. He insisted that I never allowed him to do anything. A few days later I was visiting in the cottage when A called down from his room and asked me to come up. When I arrived I found him in the process of hypnotizing one of the boys. I asked the boy

to leave. After the boy left A raged at me. When he calmed down I pointed out that he was not a physician, that he had done something illegal and dangerous, and that I did not want any harm or hurt to come to him.

In a pathetic, grateful manner, he answered: "When I lived at home my parents never allowed me to grow up or do anything for myself. Sometimes I did things behind their backs and then I felt bad inside. Because you mean so much to me and I don't want to feel bad I won't hypnotize others."

Somehow I felt this incident may have paralleled in A's mind the time his mother walked in on him and his brother C when they were involved in homosexual play. A couple of weeks earlier A had recalled this episode in an interview with me. He remembered how hysterical his mother had become and how she had screamed at him about his "naughtiness and filth." Furthermore, she had protected A's brother and had blamed A entirely for luring his brother into it. This was devastating to A.

Early the following spring A began talking to me of his feelings toward girls. He said he was no longer so shy, and found it easier to talk to girls. He began to hang around the girls' cottage and started to learn to dance. Several girls showed a pronounced willingness to get closer to A, but their eagerness frequently made him withdraw from them. He talked then of being more interested "in photography than in girls."

His hostility toward his parents lessened. He was seeing that although his parents were no different, he could get along better with them during his periodic visits home. One day he said: "Before I came here I just existed, but now I am a person." He asked me if I knew the "turning point" in his life and then added: "When you be-

came my caseworker." After telling me this, he became demanding and angry, and maintained that I never did anything for him. He wanted a car. Why wasn't I a psychiatrist? At one point he asserted that I was a "nice guy" but as a caseworker, "you stink." At another point he yelled at me: "Don't you realize that what you say affects my life? You make me sick. Every time we talk I go back to the cottage with an upset stomach and a headache."

That fall, four years after coming to the center, A began speaking of leaving and going home to live, "where school is easier." He started hypnotizing boys from my caseload. In psychiatric consultation I stressed the feeling that A seemed distressed about his feelings toward me and that aside from anger he somehow wanted to run from me. The psychiatrist pointed out that A was expressing homosexuality through hypnosis and was having a homosexual relationship with me by hypnotizing boys of my caseload. He needed to deny my importance to him and I needed to bring it out. It was felt that I should point out to him the defense and denial of his feelings. By so doing I would be supporting his ego and at the same time pointing out that it was one thing to have these feelings and another to act them out.

As I did this with A, he insisted that he was upset because I was a "lousy caseworker" and not important to him. I brought out that it was all right for him to have feelings toward me. If I weren't important to him I couldn't help him. Slowly he mellowed and said: "When I was a homosexual I used to believe I could not be cured. You told me you thought it was too early to tell and you thought I could have feelings toward girls. At first I didn't want to have feelings for girls, but now I have and maybe you can help others the way you helped me."

During that winter A continued to address himself to his leaving the center and to his future. He showed considerable concern about his inability to function on a higher academic school level. He was less sure that he could learn in school "if he wanted to." He became most angry at me whenever I pointed out that he had big ideas about his future but did nothing about them. For example, he spoke of going to college but didn't study. I questioned his desire to go to college. He insisted that he did and pointed to his parents' desires and expectations. When I wondered what his desires and expectations were for himself, he showed confusion and anger. I had, consistently, to separate him from his parents and to emphasize the importance of formulating his own goals according to his own needs and desires.

What was most noticeable in his interviews from about the fourth year of treatment to his discharge after five and a half years of treatment was that his homosexual problem no longer became the focus of our discussions. I slowly moved from defining what was permissible (talking) and what was not (acting-out) toward emphasizing that the past could not be changed but that if he wanted to do something about his present and future, he could.

Significantly, during the spring before discharge, when he was particularly anxious about his feelings of separation from me, he said: "I'm afraid that you see me by my past and as I was." He justified the changes that had come about in him by saying: "Each person has a pattern. If one is raised in a pigsty, he lives like a pig. I grew attached to my mother and I had problems. I didn't know another way of life. Then I came here, and I wanted to change. It wasn't easy. I had to fit into a different pattern, the right one. Lots of times I didn't think I could change, but

I did, and now I've learned to do things that give me satisfactions. I don't have to slip back."

The summer before his discharge, A was active in the campus council. He also had but one more semester to go before completing high school. During the summer he went to his home community to be with his parents as his father had been paralyzed. A's mother brought considerable pressure on him to stay home and assume the "father-husband" role. In conflict, A returned to the center and began his final semester of school. He needed assurance that it was all right for him to plan for himself. I recognized that, as unfortunate as his father's illness was, taking on the responsibilities of the household was too much to ask of the boy. A took a part-time sales job in one of the local department stores; he felt he had to help his parents financially.

As he became calmer about the home situation, he once again focused on himself. He spoke of being able to enjoy "little things like people and everyday occurrences." He went on to say that he accepted the fact that he would "never be a very happy person." He spoke of graduation, and of going home to live and then on to college at the start of the fall semester. At one point he said: "Don't worry. I'm not going to stay home indefinitely. I'll go to college and then the service. You see, I am really thinking of myself."

A few months before discharge A addressed himself to the changes that had occurred during his five years of treatment. Interestingly, he summarized: "I knew reality but I didn't want to change. I did it for you, but I think the environment may have been just as important as you. It's like one big experiment all mixed together, and it came out well. One thing

I can say for myself: I think I like life, and that feels good."

At the time of his graduation, during one of his last talks with me, he summed up his treatment: "There are three things that happen to a kid in treatment. First, he needs to be removed from the environment that was making him unhappy. Second, he comes to the center where he is shown new ideas and a better world. And third, he has to want to change. But once he is shown that he has problems, he usually wants to change." He ended by telling me that what he wants most in life is "knowledge" and that only by "learning" does he truly think he'll ever be "happy."

It would be deception to conclude that A is now "cured." His problems around aggression, sexuality and inadequacy continue to plague him, but his ego has developed sufficiently that he can cope with these conflicts and use his abilities more adequately. It is very likely that at some later time in life he may very well need additional help and treatment.

At the point of discharge he had become quite the "lady's man" and enjoyed a more comfortable social relationship with girls. As he became involved with a particular girl, however, he frequently or eventually dropped her, feeling he couldn't trust her.

His fear of rejection by girls and women often provoked him to reject them as a means of defense. He sensed the capacity for love and the potential to give within women but feared the possibility of their withholding or withdrawing love. Whether he could work this out sufficiently to make an adequate adjustment remained to be seen.

A came to the treatment center consumed with hate and guilt. At the time, his homosexual acting-out was an attack against all the deprivations and injustices that had

been inflicted upon him against his will. Each aggressive sexual act only increased his guilt and created further anxiety, necessitating further acts and additional guilt. Such a socially unacceptable and threatening symptom brought on considerable environmental hostility for him. He was in desperate need of love, acceptance and understanding, and the symptom of homosexuality was, in a way, a defiant act and manner of gaining love at any level, as well as a symbol of his tremendous castration anxiety and the fear of taking on a more masculine role. It is interesting that his homosexual partners were invariably younger boys (about his brother C's age). Because C as well as his brother J and sister B were so favored in A's mother's eyes, is it any wonder that A sought what made the younger ones, particularly C, so loved, adored and acceptable? At the same time, he could hostilely bring his brother and all "younger brothers" down to his level (which, according to A's self-image, was of the lowest form).

Perhaps the greatest all-encompassing quality which prevailed within A was his engulfing feelings of unending loneliness. He was in frantic need of a relationship, one that could accept him and maintain social standards which gave him the control that he lacked and longed for. The giving up of the symptom was more than he bargained for but it became possible because of his desire to please a loved adult. In attempting to control his acting-out, he became noticeably more anxious and conflicted. His ability to suppress and later repress these impulses began to increase, however, and his inner controls became effective in coping with outer stimuli. With the ability to control came stronger feelings of enhanced self-worth and confidence. Having an opportunity to express his anxiety, fears and self-hate not only alle-

viated the pressures and served cathartic purposes but enabled him to rebuild his defenses and redirect libidinal energy into culturally acceptable modes of behavior.

It is interesting to note that the facing of the homosexual symptom and the conflict concerning it led to discussion of A's basic feelings of hate and retaliation, which he harbored and repressed against his parents (particularly his mother). What emerged was an overwhelmed, damaged child who had identified, to a great degree, with the aggressor (his mother) in order to avoid complete annihilation. He had endowed her with magnitudes of power and even admired this all-powerful force which had become almost a monster in his life.

On the other side of the coin was his anger at his father. He looked to the male of the family for the protection he sought from his mother, but he found an uninvolved, passive, frightened man who allowed the mother to rage and lash out without stopping her. To A, this could only mean further rejection and abandonment.

In treatment, the caseworker played a constant and consistent ego supportive role. At times he became the target which absorbed the anger projected and transferred on to him by the boy, whose hate needed to be released and accepted without retaliation. As A began to see to whom his hostility was directed, he began to bring his parents, especially his mother, down to human-sized proportions. Slowly he learned that women were not necessarily female Cossacks who flung sabres about on helpless boys. This became most evident when he began to relate on a closer level to his female resident cottage counselor, a kindly, intelligent, non-threatening, maternal woman. This was not done without months and even years of testing inter-

mingled with all sorts of accusations and verbal attacks. This was A's pattern in every attempt at relating. He needed to provoke and reject others because he himself feared attack and rejection. Even today he sometimes resorts to this method of relating, when he is limited by someone in authority or when he senses his need for acceptance by a person in authority.

After years of testing the counselor, one day he told her: "Do you know that you and my caseworker are the two most important people in my life?" At that point he endowed the counselor and caseworker with all the qualities that he felt lacking and that he wished in his own parents.

A crucial point in A's treatment was when he re-enacted through his worker the homosexual acting-out with his brother C, in the presence of his mother, by hypnotizing another boy when it had been defined (by the worker) that this practice was unacceptable. A was needing to re-live and undo this traumatic experience and was attempting to master it by repeating it. According to Thompson:² "In the transference, the patient repeats his childhood experiences, both good and bad. It is further observed that not only do people tend to repeat earlier life situations in the transference, but there is a general tendency to repeat life patterns over and over again. Human behavior is dominated even more powerfully by the tendency to repeat former patterns of life than by the pleasure principle." With the re-enactment A was finally able to see that the adult was interested in protecting him and wanted no harm to come to him. The worker did not condemn and reject; instead, he limited A's action because of his concern for A's well-being, which to the boy was an in-

² Thompson, Clara, *Psychoanalysis: Evolution and Development*.

dication of love and acceptance. What followed was a recognition on A's part that he had done things behind his parents' back that made him feel "bad." He now felt that he no longer needed to resort to this pattern of behavior. He was now freer and able to use his resources much more adequately.

At no time in treatment did the caseworker interpret to A the boy's fears of castration, homosexual-masturbatory or incestuous fantasies. Such an interpretation would generally be avoided in casework. (The caseworker may not be able to select his clients but he can be selective in how he deals with them. A variety of casework approaches can be applied.) Instead, in this case the worker chose to provide casework that was ego-supportive, on the theory that this had much to offer an adolescent whose primary symptom was homosexual acting-out. It was an educational process in which the worker held up reality to the adolescent and thus supported his weak ego. He pointed out the unacceptable behavior (homosexual acting-out), conveyed the feeling that the adolescent could control this, and supported him when he did show control.

For example, to bring the homosexual acting out of A under control and to bring his anxiety to the surface, the worker had to take a definite, firm, non-punitive stand based on his concern and his desire to protect. To have been indefinite and non-committal would have been permissive and would almost have encouraged further acting-out. Such an approach might unconsciously have meant to the adolescent that the worker lacked standards, and eventually the acting-out might have become a delinquent interplay with the worker. By being firm and insistent, the worker practically coerced the adolescent into facing

his anger, hate and anxiety. A, was given confidence through the relationship and as a stronger ego developed, he saw that he could function successfully in many areas (as a campus council participant, athlete, cottage leader, student, salesman, etc.).

Empathy and acceptance were also important. A needed to know and understand that the worker was aware of the existence of his feelings and of how difficult they were to live with. As treatment progressed, the worker focused on the concept of self and supported the healthy part of the boy's personality. He helped him to see his separateness, to evaluate his parents more realistically, and to see, first through the worker's interest and then through other relationships, that he could be liked.

Today A manages to live with his parents and is about to enter his freshman year at a state university. There is every indication that he will be able to make an adequate adjustment to life. However, if his problems again overwhelm him, he has strengthened himself enough to know that help is available to him and he will seek it.

In such a case, psychiatric consultation helps the caseworker to understand the diagnosis, to delineate the problem and the dynamics involved, and to set realistic goals within the framework of casework methods. The casework supervisor guides the worker toward helping the adolescent learn to accept his parents, to emancipate himself from them, to develop a concept of self and to use his potentials. This combination of effort—psychiatric consultation, casework supervision and casework—brought this case to a successful conclusion.

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JOOST A. M. MEERLOO, M.D., PH.D.

Psychological remarks on the East-West controversy

Directing my thoughts and experiences to a gathering of creative writers, I feel like an intruder from a different world—one who speaks a different language, who uses different tools of communication and expression, and must grope very carefully for means of *rapport*.

I am not adept in the careful research and questionnaire techniques of professional sociologists. Neither do I have the sophistication of anthropological field workers. I am only a guest from a friendly faculty who can tell you what his clinical experiences have taught him, and what

psychology can teach us about the differences between East and West. I am not so modest, however, as to pretend that descriptive clinical experience cannot lead to usable insights. I hope that you will appreciate better the historical approach of clinical psychologists, which I hold equal in value to the experimental deduction and reduction of facts sought for by political scientists and the intuitive findings written down by creative writers.

There are various ways to approach the mysterious gap between Oriental and Occidental thinking. I want to place my personal contact with people from both cultures in the centerpoint of my ponderings.

I invite you to dwell with me in the psychiatric consultation room and hear and observe what Eastern and Western man have taught me about their inner and environmental problems. You will have to pardon me, however, if I express myself

Dr. Meerloo, a practicing analyst and psycho-therapist in New York City, delivered this address in September 1957 in Japan before P.E.N., an international organization of writers, and before convocations of the Universities of Karachi, Colombo and New Delhi. The theme of differences in ways of life in East and West was introduced as part of a general study project of UNESCO.

in typical Western idiom and if I cannot rid myself completely of some abstruse psychological terminology. Even the expression "East-West controversy" is part of a political myth involving the twain that shall never meet. The semantic origin lies in British colonialism and ancient British Discrimination.

My only justification for an intrusion into the more direct, visionary approach of the creative writer is that I have had the privileged opportunity of having intensified contact with people from opposite zones of the earth. This experience led me to believe that much that looks so controversial is part of a pseudo-problem and an artificial psychic facade. Working as a psychologist in New York—the melting pot of so many races—gave me additional opportunity to evaluate the universal human side of the problems involved. We psychologists are proud that the latest decision of the U. S. Supreme Court in 1954 on the legal equality and even opportunity for different races was based not on juridical but on psychological arguments.

Intensified personal exchange on various human values gives us the opportunity to express cultural controversies in the general human qualities which all people have in common. What usually keeps people apart is not what the other man essentially is, but the traditional stereotyped image—mainly of a negative sort—which each man projects onto his fellow man. Projection is the key word. Yet these mutual allusions and projections are difficult to correct.

One of the roots of our common bias is the general narrowing in thinking and awareness that takes place the moment we identify with our own group or with a special race or nation. The psychic fact that we belong somewhere—to a family, to a class, to a social formation with a different label—unwittingly provokes in us the

inner need to identify with a limited standpoint or ideology and to betray our sense of reality and objectivity toward others.

I had the good fortune to spend my ripening years in a neutral country—Holland—during the First World War. I enjoyed the guidance of a beloved professor in philosophy who taught us his concept of biased thought limitation. In those days the propagandistic words from both warring parties tried to catch our ears and minds. Of course, we chose our standpoint and became partisans but were not completely able to drop our teacher's concept of the unconsciously narrowed view.

Subsequently I went through the Second World War and the pains of destruction and occupation and was forced to escape from my fatherland to save my life. To repeat Stefan Zweig's words, I felt that I had no courage any more to be objective and just. For years my need to understand the other party—the enemy—disappeared and I spoke with words of bias and with melancholy disillusion about the general decline of humanity.

Yet all this could not destroy the once-experienced urge for benevolent objectivity and for enlargement of view. We all—I included—have our peculiar thought prejudices and brain limitations when special, sensitive subjects come to discussion. Then we are nearly automatically forced not to think for ourselves but to identify with special groups and their collective thoughts and to jump into various defensive attitudes because we want to belong somewhere. We all have different skins and different ancestors and we speak our prayers—or ideologies—in different ways. Our arguments and counterarguments lie ready not to prove the logic and objectivity of our reasons, but usually to serve as secret partisans of a general human hostility and aggression. It is so easy to pro-

voke those inner partisans and to let them dominate our discussions. They give release to anger and pent-up tensions but at the cost of better understanding.

So we may ask ourselves here: What is our aim? Is there an unobtrusive wish to put our cultural and racial differences to the fore or do we search for the tension-reducing goal of mutual comprehension?

THE WORLD BATTLES ON MANY FRONT LINES

The great clash of human opposites in our world has become increasingly apparent within the last half-century. Recently some of its facets have come into even sharper perspective. The implications of this spiritual and material clash are worth describing only when they can be made clear to each of us. It would be futile to speak of differences between the Eastern and Western psyche without realizing that psychological opposites are never exclusive, that their very roots are found within each human being. (In a book dedicated to the innate antinomies of man I could elaborate on this subject.)¹ At present we find ourselves, through political and social-psychological implications, bluntly confronted with the emergence of contrasts which are explained as merely racial or political while they are in fact part of the more general and universal make-up of man.

The East-West problem has become even more urgent since the relations of the big powers have changed our actual world. The Second World War pushed western Europe away from the world hegemony. America and Russia and Asia emerged as the more powerful forces with all the risks of their new responsibilities.

The solution and integration of some of the actual contrasts will have world-wide consequences. Small signs of these psychic difficulties are already apparent. These signs haunt us like shadows day and night right within our own homes when we discuss, for instance, the problems of the rumbling Middle East with its fervent fanaticism and the Asian battle cry against colonialism and discrimination. Let us not forget, however, that the development of a more intensified free democracy in the West helped to conquer the egotistic and biased concept of paternalistic colonialism among the Westerners themselves. The terms "colonialism" or "colonial symbiosis" or "colonial drainage," often used now, are as much biased—covering up feelings of inferiority—as words like "racialism" and "capitalism."

Oriental culture has generally been much more aware of the circle of bias and warped realization in which men are caught. Occidental pride too often forgets that its very picture of the world is a mental construct, conditioned and biased by the social institutions it tries to conceive and explain.

Yet we are forced to strive ceaselessly for harmonious integration and cooperation. What are some of the actual major problems involved? In our world, several—and that means a multitude—internal and external battles are being fought: hot wars and cold wars, ideological battles, delusional fights. Each side vies with the other for our favored support. It is important for us to be aware that the world battles at many front lines and that the East-West contrast is only one of them.

The contrasts in our world center only partly around the battle between freedom and totalitarianism—that nasty battle between individuation and conformity to the various party lines. The battle for greater social conformity and participation is

¹ Meerloo, J. A. M., *The Two Faces of Man*, New York, International Universities Press, 1955.

fought in all cultures where mechanization takes command. Other contrasts are the wars between capitalism, socialism and communism as economic systems and, beyond that, mechanization and technology battling with natural adjustment, moralism struggling with pragmatism, new chauvinistic superiority feelings struggling for ascendancy over national and racial inferiority feelings. We can also discern an idolatrous worship of the collective power of the masses. Through it all we see a cold intellectualism grappling with spontaneous creativity. There is the terror exerted by minorities battling democratic freedom. There is the tendency to rigid discipline over the masses grappling with that innate urge of the individual for rebellion and freedom. Even the farmer and his city cousin are in conflict; they are the symbols of man's agrarianism opposing his hovering urge for urbanization to protect his feelings of insecurity. Indeed, many battles are going on in our actual world.

Though many contrasting ideologies can be mentioned, none is limited to one special group or nation or geographical area. The contrasts are seen to cross various geographical areas. Especially in the study of the East-West contrast one finds that people everywhere have built up their huge constructs of thought. Many of those systems are nevertheless comparable with each other; throughout history people have grappled with the same problems. But it is especially the speed of development of our technological era and its illusion of a quick earthly paradise that is one of our greatest concerns now. It has done tremendous damage to the development of vital and unconscious forces in man, while its destructive potential far exceeds the integrative forces of the human spirit. But let us not forget that this very technology, this typical product from European soil,

will be able to feed the masses and free them from disease and poverty—though we will have to pay mental pains for this material gain. Yet the Orient taught us the wisdom of renunciation and asceticism and the deep scepticism about every form of material gain. It taught us the prevalence of psychic and spiritual forces, while its antinomy—the technical age—preaches to us of more and more material want and the need and urge for greater luxury, resulting in man's passivity and the fear of losing what he's acquired.

KEEP SILENT, MY FRIEND,
KEEP SILENT

My friend, the oriental psychologist, if he were asked to reflect on differences between the Eastern and Western psyche, would smile about the attempts of an occidental to write down in ambiguous words that which cannot be easily expressed. My Japanese friend would say: "Why don't you Western men seek more happiness in our oriental principle of tranquil stability? The integration of East and West will undoubtedly be established in the future, but not by one of your restless searchers for so-called objective truth and understanding. So be quiet with us; let our thoughts flow freely in limitless meditation and listen to what the intuitive voices within us will reveal to us."

"But aren't you aware of the urgent problems in the world?" my occidental haste and impatience would prod me into asking. "Eastern and Western armies are steeling themselves against each other! At any moment a shooting war may start again!" And then I will very defensively bring my own anxieties into the argument with many redundant clichés such as "colonialism . . . atomic doom . . . communism . . . the turbulent Middle East . . . the

decline of occidental culture and the decay of many other things."

My friend would only tell me: "East and West go with you where you go and are everywhere different. Don't you create your crystal-clear problems to hide the deeper and more obscure ones?" my friend, the oriental psychologist, would continue.

And then only silence would follow.

EAST AND WEST IN THE THERAPEUTIC HOUR

Nobody realizes better than the medical doctor that men are fundamentally equal. They come to him with identical pains and problems, with the same sadness and ecstasy. Man falls in love; children are born; a man dies.

When I first met a Chinese patient for medical and psychological treatment I expected a great many difficulties. My not-too-precise knowledge of oriental culture had not only inspired me with awe and respect for our oldest existing civilization but had also given me a feeling of strangeness, of something eerie that my mind could not grasp. Contact with people from the Far East, during a medical trip to their region, had always been on a formal basis—with that ritual of mutual politeness that leaves an emotional vacuum between people. We could talk about facts, even the facts of different religions and philosophies, but all the while our hidden thoughts were: "Please don't touch our private emotions and prejudices, and let us not intrude into subtle personal feelings." In addition, anthropologists had warned me about the pitfalls of cross-cultural studies and comparisons. They especially cautioned me about the too utopian view of the Far East and the idealization of the oriental aspects of life.

However, my expectations proved to be

completely wrong. The psychological treatment proceeded in exactly the same way as with other patients, though from time to time there were semantic difficulties because we were both obliged to communicate in a language that was not our own. Yet the old, eternal human problems were the same: a childhood with difficult parents, a harsh school in a country torn by war, rivalry with an older brother, the loss of the beloved bride. Here was the same outpouring of the crying child that I had experienced with other patients. Everywhere people experience the same eternal problems: the inevitability of death, the creativity of love, the deep search for freedom, the fear of the unknown. My Chinese patient told me about his peculiar background of oriental rites; it was always a pleasure for him to explain to me this exotic, unfamiliar world and to tell me what was essential or what part belonged to traditional rites. Yet it was the intense human contact of our explorative collaboration—you may call it transference—that helped him to solve his conflicts.

Later I saw patients from Java and Japan, and we met each other in the common field of universal human conflicts. Basically people are the same and understand one another in their needs. We were born in different cultures, we spoke different tongues, our historical backgrounds were different; nevertheless, we understood each other on the basis of mutual goodwill.

Why then man's preoccupation with racial, cultural and national views so easily leading to nonunderstanding and the furthering of mutually hostile feelings? People forget all too easily that we all are *in-voluntary* members of our particular national and racial groups. By birth we are compelled to belong to them, and this fact unwittingly obliges us to develop partisanship, bias and also certain loyalties regard-

less of the inner conflict we come to feel about this.

VARIETIES OF CULTURAL BREEDING

When we can accept the fact that men do not differ much in their basic physical, psychical and spiritual needs, it remains for us to discover what has brought about the fiction of unbridgeable racial and cultural differences. Could it be, for instance, that at one spot on Mother Earth one aspect of man has been more bred and cultivated and that at another spot a different human quality became emphasized? Psychology teaches us, however, that this very variety and differentiation of human aspects and qualities develops in every community where people live together; the latitude of qualities in one group is often greater than the mean differences between groups.

Everywhere when two people meet each other in a state of common immaturity a subtle hostile strategy takes place of mutual probing: who is the stronger one, mentally or physically? This strategy of expansion, trial domination and personal "colonialism" between individuals started with Cain and Abel and is still part of the power politics between individuals and nations.

Every single man is built up with a framework of various contrasting principles living within him. In every group a strong man gradually gains a dominant position as leader, causing his qualities to be an example for other members of the group. The special aspect or character of the group is greatly influenced by a common identification with the leader and his outstanding qualities. Multiply this principle of coincidental domination of specially outstanding human aspects and variations within a group by several millions (the members

of any given civilization) and multiply this outcome again—to comprise the various character types appearing within various groups in the course of many generations—and you will more easily accept the great variety of patterns into which the common human reaction-basis can branch out. Yet, surprisingly enough, the number of essential cultural patterns is a limited one while usually the variety of psychic patterns inside one group is much greater than the variety of mean characteristics of groups themselves.

Roughly, I consider a cultural pattern of totality of learned and imprinted behavior shared with members of the group and partially acquired from historical traditions and patterns, partially from new adaptations during one's own lifetime.

The psychological fact that internal variations in a group are much greater than external variations is often neglected in order to retain the need to be biased and to find scapegoats for the qualities one hates in the in-group.

When the various cultural groups look at one another with all the astonishment aroused by their differences and with all their pent-up old patterns and prejudices, it is difficult indeed to accept the thought that behind the divergent cultural developments identical hearts are beating and similar feelings are experienced. It is difficult indeed to break this myth of unbridgeable contrasts and to conquer our prejudices about irreconcilable conflicts. Communication between disparate groups seems nearly impossible because gestures, sounds, symbols and words seem to be different.

Loaded words, such as *race* and *blood* and *color*—which belong among the political catchwords of the last fifty years—have become much more the tokens of deep-seated prejudices, of bursting aggressive

drives, than of objective reason and scientific meaning. Yet these words are only the outer aspects of our stereotyped images of different cultural types.

Each one of these cultural groups, however, has a more immediate means of communication that may lead us more directly to the core of mutual understanding and intuition and that can break through the old patterns of fear and suspicion, of dread and drudgery. It is the universal expression through religious symbols and through creative art. Through the avenues of creative expression we can comprehend and empathize the religious and moral feelings and even the philosophy of those who otherwise live mentally remote from us. In this search for comprehension the East is much more direct, ideographic, working with the psychic instrument of intuition; the West is indirect and analytic, working through the instrument of connotation.

Yet the hurried psychologist in us wants all this diversity to be expressed in precise and formal technical terms of human behavior. He asks prematurely: What is the psychological motivation behind Confucius, Buddha, Islam or Hindu philosophy? Or, he may ask, to stay nearer to base in asking: What deep-seated mental complexes divided Christianity into so many different denominations and how can we integrate these schisms?

In the next part of my study I want to survey the principal thoughts about the East-West controversy that came up in actual psychology, though I am aware of the risk of modern psychology in trying to formulate problems that perhaps are not real problems.

SEARCH FOR CONTRASTS AND DIFFERENCES

The fallacy of describing psychological differences between East and West is that we

tend to interpret them in a biased way as contrasts rather than as a more or less pronounced dominance of certain human qualities and patterns that never were completely alien to our own culture and our own inner make-up. Wherever you may be in the world, tension always starts within the individual human being. Even our concept of "the oriental psyche" is a fallacy because there are as many variations between Chinese and Japanese or Japanese and Hindu habits as there are among individuals and groups in our Western culture. Yet some principal aspects as we experience them in a rashly changing world can be tentatively distinguished. Eastern man stays closer and with greater intimacy to his family group and his community. His need for discretion and reservedness, for self-distinction and privacy, for feeling his own separate inner authority is usually differently developed than in the Western world. The oriental need for being alone, in isolation, is much more part of a religious ritual in the service of concentration and meditation. Yet even in his lonely ritualistic retreat oriental man identifies with and remains part of the group.

Ruth Benedict calls more intensive group participation the core of the oriental psyche. She makes the appropriate distinction between Eastern *shame* cultures and Western *guilt* cultures. Shame and guilt are different feelings. Shame, or losing face, or feeling humiliated, is man's reaction to criticism of (and minimization among) one's own family and peers. The individual in the shame culture is and remains—much more than the Westerner—a participating member bound to his original social group. His group prescribes how he must restrain himself and what character quality he is to suppress in order to be more acceptable to the other members. Social conformism is their aim. The

individual can be rejected by his group, or ridiculed, or he may even fantasy that he made himself ridiculous. The point is that he virtually never steps out of the compact group relation, the family, the clan, the nation.

Yet I must confess that we can more and more observe this form of development of the "group-related man" in our Western institutionalized technological society. It is as if Western society moves more towards the Eastern pattern of common participation and greater conformity. Is the West forgetting its typical Western ideas: the idea of strong self-consciousness, the idea of individual freedom and the idea of the unique individual personality? Is it the intrusion and impact of the organized masses on individual thinking and personal liberty that made us have an inner uproar and accept better the concept of the Oriental psyche?

The Western concept of personal guilt and responsibility makes the individual assume a greater distance and isolation from his group. Here the individual's principal conflict is not with the group but with his inner self. Nobody else needs to know about this deeply hidden inner struggle. Man and his judging self, man and his superego or conscience, are in conflict.

In Eastern thinking, guilt and punishment belong more to an impersonal world-law, *Karma*, that gradually leads man to final purification after many reincarnations. Eastern theology is more pantheistic without the need for either a divine and superpersonal judge or an internalized judge which we call man's individual conscience.

In contrast to the group-bound individual in Eastern society, our Western society burdens the individual not only with restraint from unsocial behavior but, beyond this, with a deeper restraint and repression of his unsocial drives—as if

they no longer exist in him. Western man has to ban his feelings of hatred and destructiveness for the greater part from his consciousness, in order not to be plagued by feelings of guilt and loss of self-respect. His hypocrisy is much less conscious.

However, as said before, we discover in our Western world various transitions between this group-related and ego-related man. The so-called "organization man"—the product of our technological institutionalism—behaves more and more according to the Eastern participation pattern. His life belongs to the corporation and the institution, as if continually directed by conforming evaluations.

The anthropologist, Dr. Francis Hsu, expresses some psychic difference between East and West through his appropriate distinction between the Eastern suppression culture and the Western repression culture, in which repression represents the deeper frustration of drives. In his study on the interpretation of four cultures he gives, as an example, different attitudes toward sex. Oriental culture uses the pattern of group-directed social restraints. The suppression of sexual and aggressive drives is predominantly under the control of the group, in order to fit the individual into his culture. There is less sexual taboo and embarrassment. The West emphasizes the individual inner battle and the deeper repression of instinctual drives toward hidden unconscious regions of the mind and controlled by an often overburdened personal conscience. That is why the idealized play of romance and love acquires such an important role in Western artistic creation. Continual idealization and sublimation has to placate the burden of sexual aggression and repression resulting from so many taboos. The oriental suddenly placed in our American way of life feels surprised and amazed about our dichotomy of sexual

morals—the puritanistic repression at one side and the luring and seductive advertising at the other side.

We may say that occidental development, more than its oriental counterpart, went in the direction of greater individual isolation and distinction. I use these words—*isolation and distinction*—to indicate that there are two sides to the coin. Western man becomes the introspective, soul-searching being, feeling isolated even from his own family, confronting reality with a critical, hyperintellectual view, and morally responsible for his feelings to an inner deity, his conscience. For this social and moral isolation of the individual, the occidental world has had to pay heavily with frustration and neurotic development. I believe that it is this hyperindividualistic isolation of Western man—living, so to say, in an emotional vacuum—that stimulated the tremendous interest and growth in psychology in the West.

The inner psychic tension provoked by the greater repression and frustration enforced by Western society resulted in greater feelings of hostility toward strangers and foreigners—though incidentally, anti-colonialism and anti-tyranny may arouse the same aggressive passions in the orient. Strangers and outsiders usually represent, for oriental and occidental man alike, evil qualities that have to be inwardly conquered, repressed and expelled from man's own psyche. Racial prejudice and segregation, for instance, usually symbolize the outwardly directed hatred toward what we hate in our own souls. It is an expression of deep feelings of inferiority which ask for time and tolerance in order to be cured.

Oriental civilizations have been, in general, more receptive and hospitable toward other cultures and races. They are not so interested in the historical philosophy that has to justify the uniqueness of their exist-

ence. China is the classical example. It lost its wars but won the occupiers: the victorious invaders from Mongolia and Manchuria became Chinese. Hindu religion looks at all religions with universal tolerance. It preaches the unity of poly-form beliefs. It even accepted very early the modern physical principle that conflicting theories can be true at the same time. Yet while Hinduism was tolerant of the differences in spirit and preached a religious individualism, it proved to be intolerant of the pariahs, the people of the lower class.

That is perhaps the reason why Islam at this moment has its strong impact on the illiterate masses. The doctrinal uniformity of Islam, with its philosophical equality and urge for action, appeals to the group-directed man. The poet and Moslem philosopher, Iqbal, reproached oriental thinking for its passivity and its emphasis on contemplation. The Mohammedan uniformity of doctrine and its psychological patterns of participation may, however, make the Moslem world more vulnerable to totalitarianism.

IDEA OF ONENESS CONTRA SEPARATENESS

The oriental ideal of man, as we find it in Japan and Buddhistic countries, is in the first place that of unity and oneness, of being one with the family; one with the fatherland; one with the cosmos; one with nirvana. According to the oriental ideal, subjective man merges and identifies with the cosmos in intuitive images. The oriental psyche looks for a direct aesthetic contact with reality with undefinable empathy and intuition. Individual man is a small part of an aesthetic cosmic mosaic. Eternal truth is behind reality, behind the deceptive veil of Maja. Man is part of the universe, serving the ideal of passive resigna-

tion and ecstatic equanimity. His peace of mind is found in rest and relaxation, in common meditation, in being without manual and mental travail. His happiness is born out of the ecstasy of feeling united with the universal cosmos. Asceticism, self-redemption and poverty are still ideals in oriental culture.

The Western ideal of man is much more individualistic and distinctive. Occidental man is the rebellious Lucifer confronting the universe with his own individual self. He builds up subtle ego defenses behind his mask of imperturbability and manipulates reality aggressively with logical deductions and abstractions. In his analytic approach he seeks to reduce the cosmos to simple causal laws. He looks at unity not as a unity of all that is alive in the universe but as a unity of concepts. He wants to become independent of his teachers, eagerly trying to bypass them. Eastern man, however, wants to remain with his teacher; his *guru*.

Occidental man fears the mystic and the irrational; his is an analytic mind. That is why he is so preoccupied with the fear of death and the great unknown. He looks for outer luxury and enjoyment without expecting too much inner happiness. He talks about happiness but does not feel happy. Only the devoted and dedicated artist among Western men reaches the ecstasy of creation. The technical perfectionism of Western man may degenerate into a megalomaniacal delusion of power driven to the point of atomic destruction. In the raving frenzy of a motorized holiday many a Western man already anticipates and accepts this token of technological death.

A Westerner's peace of mind consists of maintaining the harmony of a tense inner equilibrium. The Eastern psyche is looked

at by the oriental as an expression of cosmic powers in man, the microcosmos, while Western psyche is interpreted by Western psychologists as the summation of attitudes in the individual leading to cognition and understanding.

The common need of man to belong somewhere, to have contact, to participate with others and to form a living community is solved in a more direct way by orientals than by us. While orientals fit themselves more easily into their environment—the family, the caste, the class, the nation—we Westerners do this through the medium of a fetish: a membership card, a diploma, a church label, a marriage license. The oriental in his ancestor worship has a vertical relation with his fellow men rooted in family and tribal traditions. He is a link in a historical phalanx.

The occidental has a horizontal relation, imprinted on him by the accidental labels and diplomas he wears. Our Western integration into groups is often expressed more by the official labels and sectarian names we wear than by true feelings of belonging. Even when people are sitting together watching the television screens, these Westerners are isolated, lonely individuals soothed temporarily by a sensational or an aesthetic program for which they have given up communion and conversation with their children and their friends. Not enough group life is left to ease inner tensions.

Oriental man maintains less distance from the group into which he is born and less distance from his environment. His need for discretion and reserve, for self-distinction and privacy and for having his own inner security is not so extremely developed as that of the Western soul. Living in tune and in harmony with his actual world is a true oriental ideal.

SHALL THE TWAIN EVER MEET?

Whether East and West can meet is not the real problem any more; both technology and the cult of individualism penetrate into the East; and the West goes back more and more in the direction of participation and greater conformity. Yet can man meet man? Can left meet right? Can poor meet rich? Can the gay meet the sad? This is the real psychological question. The problem arises as to whether those who live withdrawn and isolated can meet those who live with their hearts on their sleeves. Are there new universal messages that can fill in the ideological vacuum of our technical age? These are universal problems for both East and West, for Left and Right.

Basically the same mental and spiritual drives live in everyone, but in each individual the patterns and mosaics are different and there are various cultural histories, traditions and ideals to identify with. What keeps people apart is not what the other man essentially is, but the traditional stereotyped image each man projects onto his fellow man. Our upbringing and the impact of the cultural traditions and suggestions encompassing us are so powerful that it is nearly impossible to have an unprejudiced look at our fellow man. Because of different emotional aims (conscious and unconscious) the various groups and cultures create obstacles in the path of mutual understanding. Psychologically, hatred and nationalism are nearly always fabricated by resentments and dark drives of a terrorizing minority. These passions may be aroused by minorities inside the group or through contagious propaganda imported from outside.

The problem of improved relations, co-existence and intensified communicative interplay between different cultures is in the first place one of understanding and comprehension of common moral aims.

This is not a matter of continuing to try in an impractical, idealistic way to teach and berate each other, but of asking ourselves repeatedly: "What keeps other people and us so stubbornly prejudiced against mutual understanding?" In personal and in collective history we observe that differences in religious and philosophical concepts are misused to justify aggression and persecution. They are never the real causes but serve to cover up man's quixotic search for aggressive outbursts and for power and wealth.

It will take considerable time and a great deal of education and exchange of thought to correct the various internal stereotyped pictures people have of the Chinese, the Russian, the Communist, the Nazi, the Parisian, the Arab, the Jew, the Mexican, the Japanese, and so on. There remains for each of us the urgent and crucial question: "How can we possibly change these prejudiced impressions and images we have of one another?" How do we, in our divided world, fight the battle against sacred superstition? Mere diplomatic and official exchange of books or students cannot help enough in this problem, and the cold war with its hostile propaganda barrage succeeds only in transplanting the wrong images and in fortifying mutual hostility and prejudices.

Cultural and educational exchanges can be a better means to help people learn to understand what is hidden behind the racial and national masks we all put on in human contact. Reluctantly, however, I have to agree that such exchange can also serve as mere chauvinistic propaganda. Better means than these must be found to overcome the mental barriers of geographical and racial prejudices.

The crux of the question is how to familiarize the great masses of people throughout the world with the general and

universal man in each of us, the human and responsible man we all have in common. How can we give people a new and vibrant feeling of identification with the universal and common citizen of the world called *homo sapiens*?

One of the chief problems in our world is the establishment of a science of tolerance promoting the growth of man's moral capacity to tolerate each other. Only such an applied science and art will be able to neutralize that other tendency in our actual world created by the growth of material wealth—namely, the organization of dissatisfaction and resentment. The latter propaganda for unhappiness is partly done in an unobtrusive way resulting from our technical development. Yet it is also used as a huge political weapon in the hands of totalitarian strategists.

In the new mondial education for tolerance, the international club of writers, the P.E.N., the United Nations and its special cultural subdivision, UNESCO, will have their most grandiose educational task. As a matter of fact, they are already working at this task, though at present on a rather small scale. Psychology, and especially the new science of mental hygiene, can be of much help in the new development of tolerance and positive peacefare, because it teaches us to empathize and to identify with the motivations of the other fellow.

Although the creative means of communication expressed in religious and artistic symbols already give us that intimate contact needed for greater mutual understanding, psychology—if able to use the intuition and empathy of the artist—has the task of giving it a more consistent and widespread impact. Believe me, much water will have to flow to the sea before psychology will have reached that clarifying vernacular.

In mutual identification, empathy and

sympathy for the foreign man and stranger will grow. In the future the United Nations will have to do much more than it does now to reach the various isolated countries and bring them the images of other men, other cultures and other voices of humanity. A more ideal U.N. will be not only a central organ of diplomatic and scientific and cultural exchange but will reach out and build its own cultural representation and center of exchange in the different countries. A new image has to be built up: man as the universal citizen of the world. He will be shown in his manifold cultural aspects, not only in all his differences but also in all his similarities. What a challenge for writers possessed by this ideal!

Tentatively we may say that the pattern of participation and conformism we talk so much about gives, at a juvenile level of development, greater feelings of comfort and security. At least one belongs somewhere. Yet, at a more mature level, it robs people of dignity and reserve, of self-confidence and the feeling of being a free-acting unique entity.

I am sure that future psychology will speak no more of essential differences between the Eastern and Western psyche, but of their different and separate developments and what mankind as a whole can learn from these. Only the integration and impact of both cultures will lead to an intensified understanding and enhance common creative endeavor. Westerners with their accumulated intrapsychic tensions, with their pattern of individual isolation, could learn so much from the more accepting equanimity of the Eastern psyche. The more resigned and self-denying Easterner, with his pattern of greater participation, could take over part of the proud independence of Western individual-

ity. Both the orient and the occident will be enriched by greater mutual identification. Then we may repeat with confidence the well-known lines of Kipling's poem:

"But there is neither East nor West,

Border, nor Breed, nor Birth

When two strong men stand face to face

Though they come from the ends of
the earth!"

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HOWARD E. FREEMAN
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Relationship of education and knowledge to opinions about mental illness

Community programs to increase the public's understanding of mental health problems often are based on the assumption that attitudes toward mental health are linked to level of education and knowledge of psychiatric concepts. Thus, mental health education stresses giving people the facts about mental illness. In this paper we present data which do not support the assumption that opinions are linked to knowledge. Two questions are examined: Are opinions regarding the etiology and prevention of mental illness related to the level of formal education? Are opinions regarding the etiology and prevention of mental illness related to knowledge of the technical vocabulary of psychiatry?

METHOD

The data for examining these questions were obtained from a survey of the public's conception of mental illness conducted in 1950 by the Washington Public Opinion

Laboratory.¹ An area probability design was used to select a sample representative

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¹ The authors are most grateful to Prof. Stuart C. Dodd and the Washington Public Opinion Laboratory for providing us with the raw data. We, of course, are solely responsible for the analysis and interpretations herein. Preliminary tabulations of the survey were analyzed by the late Lillian B. Patterson of the University of Washington. A mimeographed report titled "Preliminary Tabulations on Mental Hygiene Poll, interviewing November, 1949," was published by the Washington Public Opinion Laboratory. We wish to note that the data were not specifically gathered to answer the questions discussed here.

TABLE 1

Variables included in the analysis

VARIABLE NUMBER	ITEM
1	Do you believe it is possible to prevent mental disorders?
2	Do you believe that people who have mental disorders get well again?
3	Do you think most mental disorders develop gradually or suddenly?
4	Do you believe that cases of mental disorders may arise from lack of will power?
5	Do you feel that dissatisfaction with your job can help cause mental disorder?
6	Do you feel too much brain work can help cause mental disorder?
7	Do you feel alcoholism can help cause mental disorder?
8	Do you feel that the parents' attitude toward a baby during the first year of its life may affect its mental health later?
9	Do you think that juvenile delinquency is related to mental disorders?
10	Do you feel that constant nagging can help cause mental disorder?
11	In your opinion, can difficulty in getting along with one's family or with one's husband or wife help cause mental disorder?
12	Do you feel that financial difficulty in the home can help cause mental disorder?
13	In your opinion, can the menopause (change of life) be one cause of mental disorders?
14	Do you feel that difficulty in getting along with the people at school or at work can help cause mental disorder?
15	In your opinion, do mental disorders run in families, that is, can it be inherited?
16	Do you feel that alcoholism may be a result of mental disorder?
17	Knowledge of psychiatric terms (total number of correct responses to 32 questions such as "shock treatment using insulin is a treatment given for diabetes").
18	Confidence about knowing psychiatric vocabulary (total score of responses to 45 terms such as <i>neurotic</i> , <i>moron</i>).
19	Knowledge of psychiatric vocabulary (total number of correct responses to 30 items, such as <i>psychosis</i> , <i>senility</i>).
20	Recognition of neurotic symptoms (total number of correct responses to 18 signals—such as loss of appetite, depression—as warning signs of mental disorders).
21	Have you ever been acquainted with a person who had a mental disorder?
22	If necessary, would you go to a psychiatrist?
23	Sex.
24	Marital status.
25	Are you a veteran (World War II)?
26	What was your age as of your last birthday?
27	What was the last grade and year you completed in school?
28	Total household income.
29	In general, and as compared with a year ago, do you feel that conditions in the United States are better or worse?
30	In general, and as compared with a year ago, do you feel that the international situation is better or worse?
31	Rural-urban residence.

of adults living in the state of Washington. Of 500 planned interviews, 483 were completed. The interview consisted mostly of items requiring yes-no responses, although a few open-ended questions were also included. In our analysis all the items were used except for a few structured ones with highly skewed distributions and the open-ended questions.

The 31 items employed are shown in Table 1. The analysis includes 16 individual items eliciting opinions regarding the etiology and prevention of mental disorders; four variables reflecting knowledge of psychiatric terms; a question on whether or not the informant was acquainted with a mentally ill person; an item on willingness to go to a psychiatrist; seven items on social characteristics, including respondent's education; and two questions measuring optimism. The variables reflecting extent of technical knowledge represent scores on four different sets of items: variable 17 is a true-false vocabulary test of the understanding of psychiatric terms; variable 18 measures the respondent's confidence regarding his knowledge of these terms; variable 19 is a multiple-choice vocabulary test; and variable 20 is a multiple-choice test of the recognition of neurotic symptoms.

ANAYLSIS

The first step in the analysis was to calculate Pearsonian correlations between the variables.² Examination of the correlation matrix provided a tentative answer to the two questions. With respect to the first—whether or not opinions regarding mental illness are related to formal education—the results are somewhat ambiguous. A correlation of .12 is statistically significant at the .01 probability level. Only six of the 16 opinion items are correlated with education at this magnitude or greater (variables

1, 2, 5, 8, 9 and 13). The average of the 16 coefficients is only .10, and the highest correlation is but .20 (for variable 8—persons with more education believe parents' attitudes toward children affect their later mental health). The data thus suggest that if there is any relationship between opinions regarding the etiology and prevention of mental illness and formal education, it is indeed a weak one.

A more definite statement can be made about the relationship between opinions regarding mental illness and technical knowledge of psychiatric terms. Of the 16 opinion items 12 are significantly associated with extent of technical knowledge as measured by variable 17, the true-false test. Once again, however, the correlations are quite low in magnitude, the highest being .26 (for variable 10—persons with more knowledge felt constant nagging could help cause a mental disorder). Likewise, there are statistically significant though small correlations between opinions and scores on variable 19, the multiple-choice vocabulary test. Thus, there appears to be a stable but quite weak relationship between knowledge of psychiatric terms and attitudes toward the etiology and prevention of mental disorders.

There are, as could be expected, strong correlations between level of formal education and knowledge of technical vocabulary. The correlation between education and score on the true-false vocabulary test is .62; between education and score on the multiple-choice vocabulary test it is .52. Education is also associated with confidence regarding knowledge of technical terms ($r = .49$), but interestingly enough there is only a low correlation between education and recognition of neurotic symp-

² The complete matrix is not included in the paper but a copy may be obtained from the authors.

toms.³ When income is related to the knowledge variables the same relationships occur, although the correlations are somewhat weaker. Thus, knowledge of technical psychiatric terms probably is not only related to education but to the variety of variables that reflects socio-economic status as well.⁴

To amplify these findings further and to see whether or not the variables could be interpreted in terms of a set of general underlying dimensions, a factor analysis was undertaken. The complete centroid method of Thurstone was employed, with factors rotated to orthogonality.⁵ Three factors were extracted before the residual matrix showed no significant departure from chance expectations. The total amount of item variance accounted for by the factor analysis is quite small, suggesting that many of the individual items are not reliable and/or there is considerable independence between specific items. Table 2 reports the rotated factor loadings, the column labeled "h²" being the amount of item variance accounted for by the three factors.

Factor 1 explains 14% of the total variance. It contains high loadings on education (variable 27), income (variable 28) and the two vocabulary tests (variables 17

TABLE 2

Rotated factor loadings

VARIABLE	FACTOR			h ²
	1	2	3	
1	.24	.33	.13	.18
2	.28	.23	.10	.14
3	.18	.23	.14	.10
4	.07	.32	.08	.11
5	.15	.53	-.07	.31
6	-.10	.44	.11	.22
7	-.05	.35	.18	.16
8	.22	.40	-.05	.21
9	.18	.42	.11	.22
10	.05	.57	-.11	.34
11	.02	.57	-.16	.35
12	.03	.55	-.10	.31
13	-.02	.42	.12	.19
14	.19	.50	-.16	.31
15	.09	.20	.15	.07
16	.07	.41	-.07	.18
17	.73	.22	-.19	.62
18	.66	.18	-.26	.54
19	.77	.13	-.24	.67
20	.31	.38	-.15	.26
21	.18	.11	-.08	.05
22	.35	.02	.14	.14
23	.06	-.32	.19	.14
24	.01	.05	.07	.01
25	.35	-.15	.13	.16
26	.47	.00	.20	.26
27	.70	.02	-.23	.54
28	.52	-.01	.03	.27
29	.23	.07	.31	.15
30	.29	.02	.20	.12
31	.09	.02	-.17	.04

³ The low correlation between education and recognition of neurotic symptoms is one of several findings not discussed in detail in this brief research note. Others of interest are the significant correlation between knowledge of psychiatric vocabulary and belief that persons can recover from mental illness, and a stable relationship between knowledge of psychiatric vocabulary and willingness to go to a psychiatrist.

⁴ See August B. Hollingshead and Fredrick C. Redlich, *Social Class and Mental Illness: A Community Study* (New York, John Wiley & Sons, 1958).

⁵ For a discussion of the statistical procedures, see Benjamin Fruchter, *Introduction to Factor Analysis* (New York, D. Van Nostrand, 1954, chapter 1).

and 19). There are only a few opinion items that load significantly on this factor (variables 5, 8, 9 and 14). The factor may be thought of as the general and specific knowledge factor.

Factor 2 accounts for 7% of the total

Opinions about mental illness

FREEMAN AND KASSEBAUM

variance and contains high loadings on almost all the items regarding opinions toward mental illness. The factor can be thought of as measuring opinions regarding etiology and prevention of mental illness. It is most notable that with the exception of variable 20—recognition of neurotic symptoms—the knowledge items are not heavily loaded on this factor. Also, neither education nor income are loaded significantly on this factor. Thus, both the Pearsonian correlations and the factor analysis suggest the relative independence of general and specific knowledge about mental health and opinions regarding the etiology and prevention of mental disorders.

The third factor explains but 2% of the total variance. This seems to be the result of a common response pattern among poorly educated rural males. Since it is of small consequence in accounting for variance, however, it will not be discussed further.

DISCUSSION

In brief, the zero-order correlations and the factor analysis indicate that opinions regarding the etiology and prevention of mental illness are only slightly, if at all, related to the level of formal education and that they are only weakly correlated with knowledge of the technical vocabulary of psychiatry.

It would be exceedingly rash to conclude from this one analysis that knowledge has

little influence on opinions and attitudes toward mental illness. But these results do call for practitioners associated with mental hygiene and health education programs to be cautious in thinking that giving the people the facts alters their opinions. Since other studies also suggest there is only a slight association between knowledge and opinions, basic research is required into the question of the frames of reference by which persons integrate factual information and personal opinion.⁶ Such research would enable the health educator to develop more realistic community mental health programs.

⁶ The problems and issues involved in mental health education are too complex to be considered in detail in this brief research note. Shirley A. Star, in a paper presented at the 1957 meetings of the American Association for Public Opinion Research, noted: "I think, too, the primary reason for the failure (of mental health education) is readily apparent; it is that mental health education has primarily devoted itself to attempting to implant its psychiatrically oriented conclusions into the thinking of people starting from different premises. Now these conclusions I keep referring to are generally called facts; you know, mental health education disseminates the facts about mental illness."

The evidence available with respect to the relationship between knowledge and attitudes, moreover, tends to support our findings, suggesting the urgency for such basic research. For example, Stouffer and his associates as well as others have noted that the attitudes of only a small proportion of individuals is determined by rational analysis of relevant facts. See Samuel A. Stouffer, and others, *The American Soldier* (Princeton, Princeton University Press, 1949, Vol. 1, 465-66).

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Status, work satisfaction and variables of work satisfaction of psychiatric social workers

This paper is a report on a portion of a larger project dealing with the status and job satisfaction of mental health workers in both state institutional and non-state institutional job settings.¹ The concern here is with the motivational characteristics of a group of female state hospital social workers, with a focus upon the relation between their status and their work satis-

faction. Conceivably, the status of the social worker may be a more important aspect of her work satisfaction than some of the more commonly considered factors, such as pay, regular work hours, preferred type of patient (client), security, etc.

The role of the social worker in relation to the others with whom she works is poorly defined. The psychiatrist, psychologist, social worker and nurse are often supposed to operate as a team, but the responsibilities of the social worker are not clearly delineated and the regulations for her behavior not clearly prescribed. The social worker aspires to a status similar to that of the psychiatrist and psychologist, while generally speaking she has less education and is more often female. For these reasons the social worker, while desiring to compete for equal status, is at a disadvantage in this competition.

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¹ S. Rettig, F. N. Jacobson and B. Pasamanick, *A Comparative Analysis of Status, Factors of Job Satisfaction and Statement of Job Satisfaction of State Institutional and Non-State Institutional Professionals*. Professional Notes No. 16, Psychological Services. Columbus, Ohio Department of Mental Hygiene and Correction, Division of Mental Hygiene.

The social worker also faces the antagonism of some of her clients. She is an intermediary between those to whom she is responsible and the client with whom she is expected to deal. Even though she is supposed to be a negotiating agent, she does not always have authority commensurate with her job.

While the total sample utilized in this study included 578 persons, our concern here is with a group of 28 social workers from three state hospitals and one state school. A group of 40 nurses are also reported on for purposes of comparison. In the original sample there were 80 social workers from various agencies and hospitals. From this group all of the male social workers were eliminated. Also, all those female social workers who did not work in the same state institution as the nurses were not used in this study, so as to match the two groups for sex and place of work. Both groups are considered workers in the area of mental health.

METHOD

The data are based on standardized individual interviews with 578 persons from five different professions and from the lay public. The professions represented were psychiatry, psychology, social work, teaching and nursing. The professionals were selected from six state hospitals and schools, from 27 clinics, agencies, general hospitals, and public schools, and from private practice. In addition, the samples included a group of 40 non-psychiatric physicians in private practice, a group of 28 psychiatric residents, and a group of 59 upper middle and 51 lower middle class lay persons.

During the interviews each person was asked to rate a set of professional specialties, according to their status and prestige, as the general public would rate them. The professional specialties consisted of the pro-

fessions comprising the sample and 12 additional professions. These individuals were then asked to rate the status they themselves desire to have (aspired status) and the status they expect to receive from their own and other professions. Each individual then rated eight factors of work satisfaction according to their importance and again according to the degree to which each was supplied to them at their work. The factors rated were intellectual stimulation, pay, status and prestige, regular work hours, security, freedom, patient respect, and type of patient. All of the above placements were secured by means of the magnetic board rating technique.² Finally, each individual answered a questionnaire pertaining to her work satisfaction and to various objective indices of status such as income, age, sex, etc.³

RESULTS

Table 1 shows the mean age, income, total objective status, aspired status, status expected from the general public, and status expected from the profession for the social workers and the nurses. On the whole, the social workers are older and have a higher income and higher objective status;

² All variables to be rated are attached to small magnets, which are placed by the social workers on a scale ranging from 0 to 100 and attached to a light steel board. The average test-retest reliability of the technique is .99 using mean judgments and .92 using individual judgments. For detailed information about the technique see Salomon Rettig and others, "The Magnetic Board Rating Technique," *Journal of Psychology*, 45(1958) 201-206, and Claude Bartlett and others, "A Comparison of Six Different Scaling Techniques," *Journal of Social Psychology*, in press.

³ There were 21 indices of objective status, such as income, age, sex, race, type of advanced degree, etc. For a detailed report see Salomon Rettig and others, "Measurement of the Objective Status of the Professional," unpublished.

TABLE 1

*Ratings given indices of status
by social workers, as compared to nurses*

INDEX	SOCIAL WORKER	NURSE
Age	3.1 ¹	2.5*
Income	4.5 ¹	3.3*
Objective status	22.8	15.8*
Aspired status	81.1	79.5
Status expected from the general public	59.8	51.4
Status expected from the profession	75.3	70.5*
Work satisfaction	11.6	12.1

* Indicates a significant difference between the means of the two groups, based on a t test.

¹ Age and income in categories.

all of these differences are statistically significant. The social workers aspire to higher status and expect higher status from the general public. The last finding is particularly noteworthy because, as will be shown later, the social workers are accorded a lower status than nurses by the general public. It can also be noted that the work satisfaction of the social worker is lower.

Table 2 shows the importance attached

to each of eight factors of work satisfaction and the subjectively felt supply of each for both groups. Although the two groups demonstrate a fairly similar pattern, there are some interesting differences. The difference between the importance attached to security and to patient's respect is statistically significant; security and the respect of their patients are considerably less important to the social worker than they are

TABLE 2

*Importance and estimated supply of eight factors
of work satisfaction for social workers and nurses*

	IMPORTANCE		ESTIMATED SUPPLY	
	Social worker	Nurse	Social worker	Nurse
Intellectual stimulation	89.4	85.8	70.1	73.2
Pay	82.8	79.1	74.3	81.8
Status and prestige	67.9	68.6	72.4	73.3
Regular hours	73.4	71.0	86.4	89.3
Security	73.9	85.0*	84.7	82.0
Freedom	85.9	81.8	78.1	78.1
Patient respect	68.0	78.8*	86.6	84.0
Type of patient	64.1	67.6	72.4	73.9

* Indicates a significant difference between the means of the two groups, based on a t test.

TABLE 3

Correlations between work satisfaction and the sufficiency (supply minus importance) of work satisfaction factors and expected and aspired statuses, among social workers and nurses

SUFFICIENCY OF	SOCIAL WORKER	NURSE
Intellectual stimulation	.32	.26
Pay	.36	.26
Status and prestige	.58*	.23
Regular hours	-.15	-.05
Security	-.19	.33*
Freedom	.61*	.68*
Patient respect	-.07	.03
Type of patient	.37	.16
Status expected from the general public	.13	-.31*
Status expected from the profession	-.22	.15
Aspired status	-.02	-.24

* Indicates a significant correlation.

to the nurse. Also, the subjectively felt supply of pay is lower for the social worker, even though they have a higher income. Both groups attach highest importance to intellectual stimulation, and least importance to preferred type of patient.

Table 3 presents the Pearsonian correlation coefficients between work satisfaction and (a) aspired status, (b) status expected from the general public and from their own profession, and (c) the sufficiency of each of the factors of work satisfaction. The sufficiency of a factor was obtained by taking the difference between the rated importance and the rated supply for each factor for each person. The most striking difference in the pattern of correlation is that, as predicted, the status of the social worker is a crucial determinant of her work satisfaction, while to the nurse security is much more crucial. The sufficiency of freedom is very important for both

groups. The relationships between aspired or expected status and work satisfaction are not significant. The highest correlations for the social worker are between work satisfaction and the sufficiency of status and prestige, and work satisfaction and freedom. For the nurses the highest correlations are between work satisfaction and freedom and work satisfaction and security. The aspired status and the status expected from the general public bear no significant relationship to the work satisfaction of the social worker. However, the status the nurse expects from the general public bears a significant, but inverse, relationship to her work satisfaction. That is, the more status the nurse expects to receive from the general public, the lower her work satisfaction.

Table 4 shows that the lay public (composed of an upper middle class and a lower middle class sample) as well as the profes-

TABLE 4

Status ascribed to institutional social workers and nurses, by an upper class sample, a lower class sample and the total professional sample ¹

	SOCIAL WORKER	NURSE
Lower class (N = 51)	35.4	40.0
Upper class (N = 59)	39.3	52.2*
Professional (N = 428)	43.8	46.6*

¹ Excludes ratings of own professional specialty.

* Indicates a significant difference between the means of the two groups, based on a t test.

sional sample accords significantly higher status to nurses than to social workers. This finding is consistent for most samples studied.

DISCUSSION

Before entering upon a discussion of the implications of the foregoing findings, it might be advisable to indicate the limitations of what generalizations can be drawn from the sample included in this survey. It should be noted first that while the qualifying phrase "psychiatric" is frequently omitted, the study was confined wholly to psychiatric social workers and the conclusions should be restricted to this group. Although the group reported upon came from four state institutions, analysis of the data indicate that this subsample does not differ significantly from the remainder of the institutional psychiatric social workers. This particular report was confined to a portion of the institutional social workers in order to eliminate the variable of place of work which we had previously found to be of importance.

Despite the finding of some differences between institutional and non-institutional psychiatric social workers, these two groups were much more alike both in self-perception and in the attitudes towards them by

other mental health professionals than either social work group was similar to any other professional group under study. It would therefore not be straying too far from the data to state that the findings arrived at would probably be applicable to the cohort of psychiatric social workers in Ohio. We have no data concerning the comparability of Ohio psychiatric social workers to those in the rest of the United States. They probably are not too dissimilar. It is our impression that fairly similar attitudes and perceptions exist throughout the country.

With these limitations in mind then, the social workers, in comparison to the nurses, are older and have a higher income and higher objective status in general. They expect higher status from the various reference groups, but actually receive less. The work satisfaction of the social workers falls below that of the nurses and is affected most greatly by the sufficiency of freedom and status. There is a tendency for the relationship between the status expected from the general public and work satisfaction to be positive for the social workers, while for the nurses it is inverse.

The most striking differences in the motivational pattern between the two groups are in the emphasis on status by

social workers and the emphasis on security by the nurses. Social workers aspire to and believe they have high status but in actuality have low status in the eye of the general public as well as in the opinion of other professional persons. One might say, in summary, that the social workers have a strong status orientation; their status is of crucial significance to them.

The low status accorded the social workers is extremely interesting since they have higher education and greater income than the nurses. In accounting for the low status of the social worker, a number of factors have to be taken into consideration. One possible interpretation of the low status accorded the social worker is that she becomes a scapegoat because of her unique position. It is the social worker who stands between the clients, relatives and community on the one hand and staffs and boards on the other. Since the social worker is the immediate and weak link in a chain of often unwelcome communication it is inevitable that the public (and the profession) she faces will direct their resentment and derogation at her. Another possibility is that the lay public associates social work with welfare activities, which may be a factor that detracts from professional status.

The criticism by professional persons may involve the training and job functioning of the social worker. "Because of the training she has received in most centers, and the incomplete comprehension by all members of the team of the nature and management of psychologic disorder, the social worker has become a psychiatrist in miniature. She has almost entirely cast aside what is, and should be, the most important aspect in her care of the patient: that is, her role as liaison between patient and society. The hard, down-to-earth task of dealing with the environ-

mental factors, of reintegrating the patient into his community, his work, and his family, which is without doubt the single most important job in psychiatric management, has frequently been almost completely neglected in favor of some shibboleth like improving interpersonal relations or another almost as meaningless. It is not the fault of the social work profession, because it has a long and honorable tradition of doing well a hard, thankless job with excellent insight and fearless honesty.* It is the concept of mental disease as an intrapsychic conflict, existing in a vacuum, which has seduced the social workers to their present status. If they do not soon take stock of their function, I greatly fear that they will find their profession will have crumbled to dust, with the psychiatrists taking their own medical histories, as they should, with trained psychotherapists doing the individual therapy, and public health nurses doing the social work as they have done so well in other medical fields."⁴

Because of the above reasons the status of the social worker is low, both in the eyes of the general public as well as in the opinion of other professionals. High demand for recognition coupled with a low supply makes for dissatisfaction, low morale and strained professional interrelationships. A rise in the status of the social worker can come about only by improved training, stronger professional organization and, perhaps most of all, better defined job responsibilities in those areas in which the social worker has undisputed authority and in which she can make her greatest contribution without having to compete for status with other professions.

*B. Pasamanick, "The Scope and Limitations of Psychiatry" in *Basic Problems in Psychiatry*, edited by J. Wortis. New York, Grune and Stratton, 1953, 43-44.

SUMMARY AND CONCLUSION

The purpose of this study is to report the findings on the status and work satisfaction of a group of state-employed psychiatric social workers from four state institutions. The report derives from a larger study of the status and work satisfaction of state and non-state employed professionals in Ohio. It was conjectured that the status of the social worker is of crucial importance to her work satisfaction.

The social workers are compared to a group of nurses. Both groups are females engaged in mental hygiene work, and they come from the same state institutions.

The findings indicate that the social workers aspire to and believe they have higher status than is accorded them by samples of various professional and lay persons. While the income, education and

total objective status of the social workers is higher than that of the nurses, the status accorded them is consistently lower. There is a significant relationship between the sufficiency of status and work satisfaction for the social workers, but not for the nurses.

In accounting for the low status of the social worker, reference was made to the ill-defined lines of authority and the ambiguous role played by the social worker. Also mentioned were the resentment and the derogation by the general public because of scapegoating by the lay public and because of associating social work with welfare activities.

It is suggested that an increase in the status of the psychiatric social worker can be accomplished by improved training, stronger professional associations and clearer role assignments.

Rewards of illness

Observations on institutionalization by a former neuropsychiatric patient

How and why does an individual become dependent upon the decisions and resources of the staff in a neuropsychiatric institution? Could it be that too much kindness and loving care fosters dependency upon a protective environment, undermining an individual's initiative and resourcefulness, independence and potentialities, so that his proclivities toward becoming a useful member of society are rendered impotent? Assuming that this is true, is this a desirable state of affairs?

It is a recognized fact that when an individual has been in a neuropsychiatric institution for a long period of time, and has become so well-adjusted to the hospital milieu that he knows or cares to know of no other way of life, he is said to have become "institutionalized." The essence of the pattern involved occurs, if one lives long enough, with most human beings. Basically it is a degenerative process. It is resignation and apathy toward the condi-

tions of their lives. It is surrender to the demands of a dispassionate "fate." Still, when this pattern is enacted in a man's youth, or in his prime, it is a tragic and premature epilogue to a life.

Self-induced failure, as a mechanism of defense, is a well-known psychiatric syndrome. It "represents a protective device which the ego uses to shield the environment and thus himself from the impact of certain instinctual drives" (1). In providing prolonged and continued asylum to such individuals the hospital is apt to defeat its avowed purpose. It can easily perpetuate the individual's difficulties and tend to strengthen his dependency upon other people's decisions and resources, leading to "institutionalization."

Sooner or later many chronic mental

Mr. Wales, a resident of East Providence, R.I., has experienced many years of intermittent hospitalization in neuropsychiatric institutions.

patients in good contact are accused of or censured for, either by others or by their own conscience, being too dependent upon the protective environment of the hospital. When others speak of this dependency it is almost always implied that these attitudes are the patient's fault, that the patient really enjoys being taken care of by others, and that such attitudes are unnecessary and unnatural. Perhaps in the final analysis this is true. But it has been the author's experience that most professional personnel, like the majority of people in the community, seem loathe to recognize the possibility that this dependency could be fostered and perpetuated in the artificial and highly structured social milieu of the hospital. Wrote Adolf Meyer in 1932: "If there is any one basic feature of modern progress in the study of psychoses, it lies in the recognition that psychoses cannot be understood and evaluated merely by observation of patients as admitted to the hospital and by a description of the full-fledged disorder, but that it is necessary to give full consideration to the broader and antecedent situations and origins, as well as the resulting developments, including the inferences worth drawing from the experience with the treatment of the conditions and management of the problem from the preventive aspect" (2).

In stressing real or fancied attitudes of dependency, little if any recognition appears to be given to the factors which tend to create passivity and reliance upon other people's decisions and resources. It should be fairly obvious that an institution, such as a neuropsychiatric hospital, is inherently notorious for inhibiting an individual's liberty and substituting "security" for "freedom." Although a patient may be told that "everything is up to you," the mere fact that medical care, food, lodging and entertainment are provided automati-

cally impresses the patient otherwise. He is told when to rise and when to go to bed, when to eat, when to work, when to be entertained. He is given, or not given, ground privileges and passes to leave the confines of the hospital at the discretion of authority figures whose power is, to all intents and purposes, absolute. And he is in most instances powerless over, and even unaware of, the criteria which influence these decisions.

A priori, he is a mental patient! And his daily interpersonal relationships with other patients, doctors, nurses, aides and ancillary personnel are fraught with the specter of mental illness. As it is usually in the nature of his illness that ego strength is diminished, surroundings replete with locked doors, rattling keys, refractory wards and men in white coats do little toward mitigating this situation. For most administrative problems appear to be intertwined with subtle force and restrictive measures. Also, when these factors are present to an excessive degree the mental patient is dealing primarily with a custodial rather than a therapeutic culture. And the degree of custodial emphasis proportionately influences dependent feelings over a period of time.

"A study of the hour-by-hour life of the patients in the average mental hospital often gives a most unhappy picture," Hyde and Solomon point out. "Not infrequently it shows a combination of idleness, inactivity, boredom and regimented uselessness. Such a situation is certainly not conducive to recovery and can create a 'prison psychosis.' Somewhere in the treatment of the mentally ill is a place for providing those opportunities for choice, expression and creativity that are so prized in democratic society" (3).

How does a condition such as dependency and institutionalization evolve? It

is a common feeling among patients that they have been unjustly deprived of their freedom. And in most instances, in one sense of the word, this is perfectly true. For very few individuals ever come to a mental hospital voluntarily. When someone becomes mentally ill, usually some other individual or agency has to step in and see to it that he receives proper treatment and care. Thus the mentally ill individual finds himself, in many instances, committed to an institution without having very much to say about what is happening to him. Naturally these steps have been taken for the mentally ill person's protection or for the protection of society. But this does not alter the fact that in most places designed for the care and treatment of the mentally ill in our culture there are a great many locked doors—which heightens his sense of restriction and detention.

Because the mental patient is involved with a difficulty labeled "illness," almost any steps taken to mitigate his problems are considered justifiable. One does not usually delve deeply enough into the issues concerned to draw parallels. One is apt to forget the lessons of history regarding tyranny and injustice. It is not easy to bear in mind that the physician and other members of the staff in our mental institutions have a great deal of power in their relations with the committed patient. This is not to be construed as a statement that tyranny and injustice exist. But it is an attempt to point out that in any environment where there is dependency upon locks and keys to control the majority of its population tyranny and injustice can flourish. At least this type of behavior can flourish far more easily than it could in an environment where physical restraints were absent. And tyranny and injustice can create dependency.

The acutely ill mental patient can, to

some extent, counteract apathy and resignation in regard to his hospitalization by building up feelings of bitterness, resentment and even hate regarding actual or imagined oppression. In most cases, though, it is otherwise with the chronic mental patient. Violent emotional responses and intellectual discord rooted in the sometimes faulty perception and evaluation of daily realities are eventually replaced by a gradual relinquishment of inward incentive, initiative and resourcefulness. The colors, the forms and weathers of surroundings that seldom if ever change close in and weigh down the spirit until there is apparently nothing to do from the patient's point of view but retreat inwardly. A repressive atmosphere of barren monotony dulls the senses until emotional spontaneity becomes atrophied and memories and dreams occupy the patient's mental life. Having, in the course of time, become conditioned and accustomed to this way of life, any sort of a change in routine becomes a painful experience. The patient has become dependent.

"In the hospital management of psychiatric illnesses, especially those of a more chronic nature, many patients improve to the point of a 'good hospital adjustment,' but fail repeatedly in attempts to return to community living. This raises the question whether hospital treatment programs contribute to the perpetuation of mental illness," Sewall writes (4). Usually the staff of the mental hospital does set up the patient's goals and then therapeutically coerces the patient to strive toward these goals. Naturally, if the end result doesn't materialize the way the staff had planned, the patient is apt to be censured or punished, and the fact that social drill, or an enforced conditioning process, can be far less effective than mimesis is ignored.

It must be remembered that these re-

marks are not intended as an indictment, but as observations regarding one deplorable, and perhaps unavoidable, facet of institutional management. Moreover, they are a plea for recognition of the fact that daily, all over our land, there are a certain number of men and women who are sitting unhappily and unproductively on hospital wards designed for those who are actually acutely or chronically ill. Men and women who, if given the proper understanding and encouragement, hopefully might order and sustain their own lives in the community. As one authority has said: "The hospital's functioning should be geared to produce a situation of flexibility where the problem of first treating the sick patient and then aiding him to make the transition from the hospital to the community is of prime consideration" (5).

The major part of the treatment program for the chronic mental patient, in most of our mental hospitals, appears to consist of prolonged milieu therapy. And milieu therapy in an institutional setting, in some cases, is woefully lacking in benign opportunities for individual growth. Milieu therapy appears to be aimed at resolving those facets of a patient's illness which is directly related to and affects the prevailing mores and customs of society. In short, the rights of society appear to be considered of more importance than the rights of the individual. It is not within the scope of this paper to delve into the merits of the various aspects of the question as to which is the more important. But it is assumed in this instance that as a hospital, according to most dictionaries, is "a place in which the sick and injured are cared for," the sick or injured individual is the more immediate concern.

In some respects, of course, all of us are dependent upon one another. But when

an individual becomes dependent upon others to such a degree that he is unable to take care of his own needs and is unable to function adequately in the extramural community, neither the individual nor society benefits. Professional personnel have been known to comment that the neuropsychiatric patient lacks sufficient motivation for displaying healthy attitudes. Still, as Patterson pointed out, "apparently mental patients are much like the rest of us and will respond to attention—with improved performance" (6).

Mr. X, a geriatric patient, was a competent oral surgeon and a minor political figure in a southern community. He is married and has two grown children who are financially well off. He himself is comparatively well-to-do. For a number of years he has been hospitalized in a state hospital for mental diseases in New England. Although he is a World War I veteran with a service-connected disability, he prefers to stay where he is rather than go to a Veterans Administration hospital. He is an amiable gentleman in his early sixties possessing an alert intelligence. In the hospital he enjoys many privileges denied and even unknown to the average patient. His principal complaint is that he has a heart condition, although he will admit when pressed that the doctors have never been able to find anything organically wrong.

Here in the eyes of the layman is a highly educated gentleman with a vast background of experience, potentially a useful member of society, who is spending his declining years unwanted and to all intents and purposes useless to himself and others.

Unfortunately psychiatry is still in its infancy. For many, mental illness is still a fearful thing. Also there is a stigma attached to it. Nevertheless, the oft-repeated

contention that long periods of confinement is a salubrious experience makes a mockery of truth.

Mr. Y, plagued by what appears to be a severe anxiety neurosis to the layman, was a professional photographer in his early twenties. While on pass some months ago he became intoxicated and fell asleep in a restaurant. Picked up by the police and charged with being drunk and disorderly he was brought into court where he was placed on probation. Upon his return to the hospital he was removed from a fully privileged ward and placed on a refractory ward where he spent several months in the company of very regressed psychotic patients. Upon regaining his status as a privileged patient residing on an open ward, he was given frequent passes in his own custody. At the same time the staff, not too diplomatically, impressed upon him that if he got into the least bit of trouble he would be summarily transferred to a correctional institution for an indefinite period of time. After starting out on a week-end pass he became apprehensive and hurriedly returned to the security of the hospital, vowing to forego passes in the future.

In an editorial a few years ago the *Lancet* noted that "There are two historical reasons for the constraint of the mentally sick (who of all people are least able to tolerate it): first, the public demand for protection from something fearful and unintelligible, and secondly, the belief that self-discipline could be instilled by force" (7).

Mr. Z was hospitalized for a psychoneurotic condition complicated by a mild addiction to alcohol. A competent worker in his middle forties, he was soon satisfactorily fulfilling the duties connected with his work assignment in the dietary department

of the state hospital where he had been committed. Transferred to a Veterans Administration hospital for further treatment, he became despondent and began brooding about the loss of his freedom. He then commenced drinking heavily while on pass. This soon resulted in a temporary loss of privileges, which added to his bitterness and resentment. Upon regaining his former status at the hospital he soon repeated the episode.

This same pattern, with variations, was continued during approximately three years of hospitalization. Mr. Z halfheartedly attempted suicide on two occasions while he was inebriated during this period of confinement. Transferred to another Veterans Administration hospital closer to his home he continued to display frequent gestures of rebellion. There were numerous elopements and two suicidal attempts plus frequent alcoholic bouts within the confines of the hospital during nearly six years of continuous hospitalization. Within hours after he had been given a maximum hospital benefits discharge he was seeking readmittance to the hospital. This request was denied. When heard from last he was again in a state hospital, primarily for alcoholism.

Upon meeting Mr. X, Mr. Y and Mr. Z one would not be prone to think of them as mentally ill. Even after talking with them and observing them over long periods of time one would be hard put to discover any evidence of psychotic or discernible abnormal behavior as understood by the average individual. None of them was assaultive, destructive or hallucinating in his daily behavior. They were competent conscientious workers who were liked and respected by others. None of them used an abnormal amount of obscene language, none of them was particularly irritable, nor did they display an anergic attitude toward

their daily activities. Their movements were not manneristic and they were not deluded in any particularly bizarre fashion. And certainly none of them was seclusive.

Still, all of them had been hospitalized for long periods of time. They had, like all chronic patients, been uncompromisingly conditioned to the passive acceptance of a loss of physical mobility. Sooner or later, circumstances had forced them to adjust to the fact that a great deal of their time and energy must be spent in coping with confinement or in following a routine of unchanging rigidity. This, as with most patients, conflicted with the normal daily pattern of living which they had enjoyed before they became ill. This combination of circumstances—the fact that like most mentally ill individuals they were, except for the doctor, not in the hospital willingly, and once in the hospital they had been confined on closed wards—accounted for much bitterness and resentment regarding their hospital experience. And propaganda aimed toward the disavowal of those circumstances could serve no purpose other than to perpetuate the problem—which, in its essence, was one of strengthening, not undermining, the therapeutic program.

More than a hundred years ago Thomas Carlyle wrote that "The great law of culture is: Let each become all that he was created capable of being; expand, if possible, to his full growth; resisting all impediments, casting off all foreign, especially all noxious adhesions; and show himself at length in his own shape and stature, be these what they may" (8).

In practically all mental and emotional disorders, the ego, or the individual's conscious idea and understanding of himself and his relationships to the world in which he lives, is adversely affected. And a wounded, faltering ego is in no position to deal with life's everyday problems, least

of all confinement and regimentation. Without our self-respect or our self-esteem none of us is of much use to ourselves or to others. Unwarranted restrictive measures are never conducive to growth.

Reliance upon the hospital for support at a time when an individual is mentally or physically unable to provide for himself is understandable. But it is illogical for hospital management to maneuver or allow itself to be maneuvered into a position in which it accepts responsibility for the welfare of an individual who does not need and does not consciously want this care and treatment. This is doing a disservice, both to the patient and to society. Making a "good hospital adjustment" implies to the layman that, if the institution where an individual is hospitalized is therapeutically oriented, he should be considered well and ready for discharge. Unfortunately, where custodial care in a neuropsychiatric institution is the principal motivating factor, discharge of a patient when he has reached the peak of his capabilities and capacities for health seldom occurs. Thus a benign equinox in the patient's growth passes unheeded and his original emotional difficulties are eventually intensified. "The factors that influence the development and course of mental illness have been classified by one authority (Dr. Nolan D. C. Lewis) as predisposing, precipitating and perpetuating. Little can be done in adult life to modify predisposing factors. Precipitating factors are ordinarily of brief duration. The major problem in the treatment of emotional disorders, therefore, is dealing with those factors that influence the course of mental illness—the perpetuating factors" (9).

Throughout the span of recorded history sin, in the minds of certain individuals, has somehow been associated with illness—as though man alone were entirely to blame

for his misfortunes. Over the course of the past few centuries, as medical men have gained knowledge and understanding, man's physical infirmities have, for the most part, come to be accepted with tolerance. Man cannot be expected to control invisible bacteria all of the time. This evidently is not so, though, with mental illness, even though long-forgotten experiences are thought to be partially responsible for the mental patient's confused, inadequate responses to today's stimuli. If it were, we would not have so many locked doors in our mental institutions. Mental illness would be strictly a medical problem, not a sociological problem also!

It would be superfluous to dwell here on the fact that mental illness in America has become a staggering problem. Conceivably, one day, any deviation from the mores and customs of the majority, by an individual, could lead to his being classed as mentally ill, thereby making him eligible for hospitalization. This is one of the reasons why it is felt that far too little attention is paid by professional personnel to those individuals confined in mental institutions who are not, medically speaking, psychotic. And who, being dangerous neither to themselves nor to society at the time, do not constitute a medical problem requiring hospitalization.

Actually, of course, this is another facet of that larger problem known as "institutionalization."

Like any efficient business organization, the management of a hospital for mental diseases is consciously interested in disseminating effective propaganda concerning the patient's hospital experience, to the patients themselves, to relatives and to the public at large. As with all propaganda, much that is said is directed toward allaying doubts and overcoming what might be termed resistance regarding the methods

of treatment and the goals of hospitalization. Little is heard, though, about the patient's real thoughts and feelings concerning hospitalization and the loss of his freedom. And time after time one sees men and women who have regained their health still in the institution.

It is like hospitalizing a man with a broken leg and then keeping him in the hospital for months and even years after the leg has healed—rationalizing the situation many times by saying that if the patient were discharged he or she might go right out and break the leg all over again. Ludicrous as that may sound, there would be many tragic facets to such a situation. Innumerable new problems would be created having nothing to do with the original broken leg. Foremost among them would be the problem of dependency as it is related to "institutionalization." Bearing in mind that this is greatly simplifying an idea of dependency as an iatrogenic entity, and that generalizations are dangerous, one may attempt to visualize the various implications of such a situation.

We generally equate normality and the average individual with one who is successfully ordering and sustaining his or her life in the extramural community—an individual who is capable of, and in a position to pursue, life, liberty and happiness in accord with the demands of his constitutional proclivities. At the onset and during the course of an illness many of these things, which have been utilized and enjoyed heretofore as a matter of course, are nullified. This is to be expected, and little or nothing can be done to alleviate matters at that time. But we should not lose sight of our perception and understanding of "freedom," even though it is different with each of us.

What are the rewards intrinsic in the institutional structure? What are the re-

wards of illness? Primarily, of course, as has already been pointed out, the patient has no concern about where his next meal is coming from, where he is going to sleep or where he is going to find shelter from the elements. All of these things are taken care of for him by powerful authority figures who will brook little or no criticism in most instances. Many times the patient feels that he must inhibit any criticism of the staff or of the organization of the hospital, lest he be transferred to a refractory ward.

The chronic mental patient can usually make no decisions of his own except in the most trifling matters. True, ground privileges for good behavior and the occasional pass home (usually in someone else's custody) are matters that, on the surface, ultimately appear to depend upon the patient. But for the long-term patient who has had months or even years of hospitalization behind him the incentive and inclination to leave the refuge of the ward or of the hospital has all but vanished. He has usually tried too many times to surmount the barriers that separate him from the extramural community. Perhaps friends or family are no longer waiting for him. Or perhaps their philosophies are so imbued with the fact that he is considered a chronic case that he no longer has the desire to make an attempt to meet them on an adult basis of equality. And perhaps he has been made to feel that he is somehow different and has finally come to prefer the society of his own kind—other mental patients.

Abnormality, for this type of patient, has become normality over a period of time. "The statistically normal mind can be regarded only as a mind which has responded in the usual way to the molding and deforming influences of its environment—that is, to human standards of discipline,

taste and morality. If it is to be looked upon as typically healthy also, the current human standards of whose influence it is a product must necessarily be accepted as qualified to call forth the best in the developing mind they mould" (10).

To function properly, both physiologically and psychologically, each of us must possess some measure of freedom. Applied to the mental patient this might be termed physical and mental mobility. The artificial barriers so prevalent in the institutional environment must therefore obviously be inherently antitherapeutic in their effect upon the patient. Even the most regressed patients perceive this and express their longing and hunger for freedom, in acts of aggression and in apathetic behavior, in an effort to solve the problem. Propaganda to the effect that all behavior of this type is entirely dependent upon inward factors and the course of the patient's illness thus can be a distortion of the truth. Conversely, elopements and other management problems cannot always be explained on a strictly medical basis. It is not necessarily a symptom of mental illness to think it expedient to abandon or seek escape from an unbearable position.

For most of us freedom means being at liberty to make our own decisions. Simple decisions like where and when and what to eat. To be able to work, and to play, and to rest, in accord with the demands of our natures. To be able to choose and pursue, unhampered by another man's moral judgments and autocratic controls, those avenues of expression most in keeping with our individuality. To be in a position to expend our energies in harmony with the rhythm of growth unique with each of us alone. To be free to acquire the wisdom and knowledge most in keeping with our inclinations and tastes—Regardless of the social level of this pursuit

of happiness. To be in a position to combat the coercion and ill-considered advice and opinions of others. And to be free to shun the well-intentioned tyrannies thoughtlessly imposed upon us by others, which tend to make us hypocrites. When we are abundantly in possession of these intangibles most of us function fairly adequately—if we have our health also—both in our relations with ourselves and in our relations with our fellows.

The mental patient has lost the ability and the opportunity in many instances to enjoy most of these things.

It is a paradox that when a long-term patient is released from a mental hospital the reaction from the accumulated emotional tension and intellectual conflict prevalent in an environment where, to a greater or lesser extent one is dependent upon the decisions and resources of others, may for some time lead to more rather than less difficulty in the man's readjustment to the accepted normality of society at large. Hospitalization may have eradicated the overt symptoms of his illness at the expense of his character, personality and individuality as a human being.

SUMMARY

The author has attempted to point out some of the malignant facets of long-term hospitalization for the non-psychotic neuropsychiatric patient. Primarily a concept of iatrogenic dependency has been stressed. The author has attempted also to point out that months or years of a man's life spent segregated from the extramural community, with little or no contact with the

prevailing mores and customs, produce changes in the man, and indirectly in his family and friends, from which recovery is neither immediate nor easy.

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The family as a potential resource in the rehabilitation of the chronic schizophrenic patient

An important focus of the recent interest in the hospitalized mentally ill is the patient's relation to his family and community. For the chronic schizophrenic patient, tranquilizing drugs have brought renewed hope of increased contact with the outside world. This same goal has been the aim of the social therapies for many years. These include occupational and recreational therapies, work and rehabilitation programs, and extensive contact with hospital personnel.

Mrs. Evans and Dr. Bullard are on the staff of the Massachusetts Mental Health Center in Boston. The investigation reported here is part of an ongoing research grant supported by the National Institute of Mental Health.

¹ Bullard, Dexter M., Jr., M.D. "The Relative Value of Ataraxic Drugs and Social Therapies in the Treatment of Chronic Schizophrenia" (submitted for publication).

An investigation of the relative value of drug and social therapies in the treatment of chronic schizophrenia was undertaken at the Massachusetts Mental Health Center. A group of chronic schizophrenic patients was brought to the center and treated with tranquilizing drugs and social therapies for six months with the aim of rehabilitation and discharge.¹ During this study the improvement in many patients which seemed to warrant discharge did not always result in discharge. The success or failure of plans for discharge was often found to be dependent on the relationship between the patient and his family. This led to a study of the factors that influence this relationship.

The present report will describe the relationship between the chronic schizophrenic patient and his family. It will present a picture of the patient's behavior on the wards

of the Massachusetts Mental Health Center, of his behavior with his family, his social and occupational skills and his financial resources. The family will be examined in detail, including the home situation, the extent of the family's interaction with the patient and the family resources available to the patient.

CRITERIA OF SELECTION

The subjects were 24 inpatients of the Metropolitan State Hospital, Waltham, Mass. All had been continuously hospitalized at least 5 years with a diagnosis of schizophrenia.² There were no diagnoses of organic deterioration or mental deficiency. All patients were between the ages of 25 and 50; their average age was 38 years and their median age was 37 years. The average length of hospitalization was 11 years and the median length of hospitalization was 10 years. There were 14 women and 10 men in the group. Selection of these patients was made by random sample from the 46 patients at the Metropolitan State Hospital fulfilling the criteria of selection.

The families in the study included parents and siblings (families of orientation), spouses and children (families of procreation), and collateral relatives of these patients.

METHOD

The patients were transferred to the Massachusetts Mental Health Center beginning in November 1956 at the rate of one per week. They remained for a 6-month period unless discharged earlier. The patients remaining at the end of 6 months returned to the Metropolitan State Hospital. During the 6-month period at the Massachusetts Mental Health Center they were treated with a combination of tranquilizing drugs (chlorpromazine and reserpine) and with

intensive social therapies. These social therapies included psychotherapy, social casework therapy, contact with students of various disciplines, occupational therapy and a rehabilitation program. The rehabilitation program covered work opportunities inside and outside the hospital and training in job skills.

Material for this report on the patients and their families was gathered following the patients' transfer to the Massachusetts Mental Health Center. The patients were interviewed by a psychiatrist and observed by a social psychologist to determine their psychiatric and social disability. A history of the patient's illness was obtained from the Metropolitan State Hospital record. The patient's individual psychiatrist reported his evaluation of the patient's progress during the 6-month period. The patient's job and social activities at the Massachusetts Mental Health Center were recorded at the time of the study.

The families were interviewed by psychiatric social workers of the center's inpatient adult unit. Because the hospital records were inadequate, the research staff obtained information from social service interviews with the social worker about the number of living family members, the number of family visits prior to transfer from the Metropolitan State Hospital, the family's perception of the patient's illness, and the family's attitude toward the patient's release. At the time of admission to the

² The specific diagnoses by the hospital staff were as follows:

Schizophrenic reaction, paranoid type	6
Schizophrenic reaction, catatonic type	5
Schizophrenic reaction, simple type	2
Schizophrenic reaction, hebephrenic type	1
Schizophrenic reaction, chronic undifferentiated type	10
Total	24
	65

Massachusetts Mental Health Center, information was also gathered from the family concerning the patient's and family's resources. Supplementary data concerning the financial resources of the patient and family were obtained from the Massachusetts Department of Mental Health.

LIMITATIONS OF THE STUDY

The authors are aware of the small number of cases and many descriptive categories; therefore, the data will deal with trends rather than statistically significant information. We have purposely limited this report to a description of the family as a potential resource and have omitted any data about the family's role at discharge. This will be discussed in a later report.

OBSERVATIONS OF THE PATIENTS

As Richard York points out,³ the chronic schizophrenic patients "have settled down to a minimum level of activity and social interaction . . . they have slipped into an isolated, anonymous, apathetic condition." These patients at the Massachusetts Mental Health Center showed many of the characteristics of the long-hospitalized chronically ill patient. In interacting, they were distant, remaining by themselves unless invited to join in a social situation. When approached, most were quiet and reserved, discouraging further contacts. Despite this difficulty in making social contacts, these patients generally took responsibility for themselves. The majority (58%) took care of their personal appearance and clothing adequately. Three-quarters of them lived on open wards, went to the cafeteria for meals and to other parts of the hospital for

activities. Over one-third (38%) made some use of privileges to leave the hospital during the day for walks, job-hunting or trips to the drugstore. Two-thirds worked at some daily ward task—sweeping, making beds or waxing floors. One-half of the patients worked regularly at some job in the hospital—in the coffee shop or on the paint crews.

In their relationships with their families this group of patients took little initiative. None were active in phoning, writing or visiting their families, even patients with full privileges. One patient pretended indifference to his family, only to break down and cry when visited by his brother. When they were visited or taken out for weekends by their families, the patients were usually docile and, though pleased, did not themselves take steps to continue the family contact.

The patients' resources reflected the disability of their disease as well as the effects of prolonged hospitalization. None of the 24 patients had any personal income and none had any savings, as might be expected after five years or more of hospitalization. Their job aspirations were limited; few had acquired a trade prior to their illness. Only three of the 24 had held a skilled job. Added to this, none of the patients had held paying jobs during their hospitalization. More than one-third (38) were still in school when they became ill.

Thus, because of the patient's inability to handle his life situation, other resources had to be explored before there could be any change. The primary potential resource available to the patient was his family, and it was to the family that the patient and the hospital looked for assistance.

OBSERVATIONS OF THE FAMILIES

Our interest in the family covers three areas: (1) the family situation, (2) the rela-

³ Greenblatt, M., R. York and E. Brown, "From Custodial to Therapeutic Patient Care in Mental Hospitals." New York, Russell Sage Foundation 1955, 354.

tionship between the patient and the family, specifically the patient's illness and the family's attitude toward his release, and (3) the family resources available to the patient.

A study of the family situation showed a dearth of family members. This lack extended to the families of orientation (parents and siblings), of procreation (spouses and children) and collateral relatives (aunts, uncles, grandparents).

By the time of transfer to the Massachusetts Mental Health Center, a majority of patients (17) had lost one or both parents. Five patients had no parents at the time of transfer. Three patients had no available living relative. Nineteen patients were not married. Of the five patients who were married, none had spouses to go home to because of legal separation or divorce.

Thus, a member of the family of orientation rather than the spouse was legally responsible for the patient. Despite the absence of parents and spouses, 21 patients had living siblings. This would appear to

be a primary resource to the patient. Many siblings, however, lived outside the Metropolitan Boston area.

For example, the family of a 37-year-old divorced man consisted of his aged mother and a younger married brother. Contact with Mr. A's family was limited by his mother's inability to come to the hospital because of her infirmity. His brother lived in Rhode Island.

Noteworthy was the fact that many families remained interested in the patient even after prolonged hospitalization. Twenty-three patients were visited at the previous hospital by their families and two by friends. This is summarized in Table 1.

Prior to transfer, one-half (12) of the patients were visited once a week and an additional five patients were visited once a month. Though the frequency of visits appeared to drop off after the patient had been hospitalized for 13 years, a majority of families continued to visit the eight patients hospitalized more than 13 years.

TABLE 1

Family visits in relation to length of patient's hospitalization and sex

and sex

NUMBER OF PATIENTS VISITED											
Length of hospitalization (years)	Once a week		Once a month		Holidays only		Never visited		Subtotal		Total
	M	F	M	F	M	F	M	F	M	F	
5- 8.9	1	3	1	1	0	0	0	0	2	4	6
9-12.9	1	4	1	0	1	0	2	0	5	4	9
13 and over	1	2	1	1	0	0	1	2	5	5	8
Subtotal	3	9	3	2	1	0	3	2	10	13	—
Total	12		5		1		5		23		23*

* In one female case whose length of hospitalization was 17 years, the number of family visits was unknown.

M = Male.

F = Female.

TABLE 2

Family's perception of illness in relation to patient's total hospitalization

LENGTH OF HOSPITALIZATION YEARS	"HOPEFUL"	"HOPELESS" *	TOTAL
5-12.9	11	3	14
13-20.9	4	4	8
Total	15	7	22**

* "Hopeful" means the family felt the patient's chances for recovery were "good" or "fair." "Hopeless" means that the family felt the patient's chances for recovery were poor.

** In 2 cases the family's perception of illness was unknown.

The female patients were visited more often than the male patients. The patients' age did not correlate with visits made by the families.

FAMILY'S PERCEPTION OF ILLNESS

The family expressed a wide range of opinion regarding the patient's illness. This is shown in Table 2. Fifteen families perceived the patient's illness as being curable or they were uncertain about curability. Of the eight families who thought the illness curable, three did not feel that the patient was ill. Samples of families' remarks were: "He doesn't really need hospitalization" and "I don't believe he's really sick—just too timid." The remaining five families were optimistic about discharge as a result of the transfer to the Massachusetts Mental Health Center. "She's been in the hospital a long time. Perhaps now she can get out."

Seven families were uncertain whether the patient's illness was curable or not. One family expressed this in the following: "She's been sick a long time. I hope she

gets better but we really don't know what the chances are."

Seven families said that the illness was incurable: "A hopeless situation beyond anyone's control" or "Been in the hospital too long to be cured."

In two cases the family's perception of the patient's illness was not known. The family's perception of illness did not correlate with the patient's age or sex.

The family's attitude regarding the patient's illness did seem to correlate with the length of the patient's hospitalization. Of those families who were "hopeful," eight, or one-half, felt the patient's chance for recovery was "good" and the other families felt the patient's chances were "fair." All of these patients whose families felt that the chances for recovery were "good" had been hospitalized less than 13 years. After 13 years of hospitalization, one-half of the families felt that the patient's chances of recovery were small. This feeling on the part of the family is in accord with studies⁴ indicating that the prognosis for patients becomes worse as the length of hospitalization increases. No correlation was found between family visits prior to transfer and the family's perception of illness.

⁴ Greenblatt, M., R. Arnot, and H. C. Solomon, *Studies in Lobotomy*. New York, Grune and Stratton, 1950, 181.

TABLE 3

Family's attitude toward patient's release in relation to familial perceptions of patient's illness and sex of patient

	ATTITUDES TOWARD PATIENT'S RELEASE						
PERCEPTIONS OF ILLNESS	<i>For or ambivalent</i>		<i>Against</i>		<i>Subtotal</i>		<i>Total</i>
	<i>M</i>	<i>F</i>	<i>M</i>	<i>F</i>	<i>M</i>	<i>F</i>	
"Hopeful"	4	8	2	1	6	9	15
"Hopeless"	1	2	2	2	3	4	7
Subtotal	5	10	4	3	9	13	
Total	15		7		22		22*

* In 2 cases the family's attitudes were unknown.

FAMILY ATTITUDES TOWARD RELEASE

Although all of the patients were hospitalized continuously over five years, the families expressed an interesting difference of opinion regarding the patient's release. Eight, or one-third, of the families favored release. Remarks such as "The family can take him," "Everyone wants him home" and "Sister is willing to take him" were made. Seven of the families were uncertain about release. They wanted the patient home but only if he had no outbursts. Eight⁵ of the families, or one-third, were against release

unless the hospital guaranteed complete cure.

Most families who saw the patient's illness as being curable favored release. One mother felt that her daughter was not mentally ill and was anxious to have her at home. Four of the seven families who considered the patient's illness incurable were opposed to release.

The families of the women patients favored release more often than those of the men, who expressed fear of aggressive acts.

⁵ One family's attitude was unknown.

TABLE 4

Family's attitude toward patient's release in relation to family visits

	ATTITUDES TOWARD PATIENT'S RELEASE		
	For or ambivalent	Against	Total
Once a week	10	2	12
Once a month	3	2	5
Holidays only	1	0	1
Never visited	1	4	5
Total	15	8	23*

* One family's attitude is unknown.

TABLE 5

Attitudes of families who were for or ambivalent regarding patient's release in relation to patient's sex

SEX	EXPECTATIONS OF FAMILY			Total
	Minimal maintenance *	Assistance in home *	Partial or complete independence *	
Male	3	0	2	5
Female	6	4	0	10
Total	9	4	2	15

* Minimal maintenance means that families expected the patient to feed and clothe himself. Assistance in the home means they expected the patient to help in the home—make beds, wash dishes, baby sit, etc. Partial or complete independence means they expected the patient to take over his or her former role—for the male to assume financial independence and for the female to take over the duties in the household.

For example, the father of one 32-year-old man was afraid that he would harm the children in the household.

The family's attitude toward release did not correlate with the patient's age or length of hospitalization.

As Table 4 illustrates, the families who frequently visited the patient were most interested in his discharge. One-half of the families who were against release never came to see the patient.

The families who favored release (15) did not have unrealistic expectations of the patients. A majority of these families required only that the patient be able to maintain himself in the home. Further, no female patients were expected to provide financial assistance.

Once again there was no correlation between the patient's age or length of hospitalization and the family's expectations.

FAMILY'S AVAILABLE RESOURCES

Financial

The families were generally in the extremely low income group. The financial

resources were discussed in 23 of 24 families. About two-thirds made less than \$3,000 annually. The median income of these families was \$2,500 a year, considerably less than the national family median income of \$4,971⁶ a year.

Fourteen families stated they would be able to assist the patient; three families were able to assume complete financial responsibility, 11 partial responsibility. Nine families could not give any kind of financial assistance.

Family income came from a wide variety of sources. Seven families were supported by resources outside the family of procreation; three families were not self-sustaining, being assisted by collateral relatives. One family was getting unemployment benefits. One family was supported by aid to dependent children and 2 families received old age assistance.

Living arrangements

Twenty families discussed their living arrangements with the social workers. Despite being in the low-income group, 11 or slightly over one-half of these families stated they could be responsible for living arrangements. Nine felt they had room for the

⁶ U.S. Bureau of Census, *Population Series T60*, No. 29, June 1958.

patient at home. Two offered to subsidize apartments if the patient were discharged. Nine stated they could make no provisions for the patient.

Employment

Very few families were able to help with paid employment. Eighteen discussed the possibilities of employment. The members of only one family felt they could help the patient get a job. Seven families told the social workers that they would give the patient unpaid employment in the home. Ten

could not make provisions for the patient's employment and felt he or the hospital would have to assume this responsibility.

Recreational activities

We found nothing conclusive about this aspect of the patient's rehabilitation. The question of recreational activities was discussed in only 10 cases. In nine of these cases the family had outside interests in which the patient could join. These groups were either social or religious clubs. Only one family said that they did not belong

TABLE 6

Resources of the family in relation to the family's attitudes toward the patient and toward release

RESOURCES AVAILABLE FOR THE PATIENT	PERCEPTION OF CURABILITY OF PATIENT'S ILLNESS			FAMILY ATTITUDE TOWARD RELEASE		
	"Hopeful"	"Hopeless"	Total	For or ambivalent	Against	Total
Financial						
Yearly family income:						
\$2,000—over	5	5	10	7	4	11
0-1,999	9	2	11	7	4	11
	—	—	—	—	—	—
Total	14	7	21	14	8	22
Living Arrangements						
No provisions	5	3	8	5	4	9
Have room at home or could subsidize apart- ment	9	2	11	10	1	11
	—	—	—	—	—	—
Total	14	5	19	15	5	20
Employment						
Cannot make provisions	7	2	9	8	2	10
Family can help patient get a job or can give unpaid work at home	7	1	8	7	1	8
	—	—	—	—	—	—
Total	14	3	17	15	3	18

Note: The totals represent the number of families whose resources and attitudes were known at the time of transfer.

to any clubs, but that they did entertain and would include the patient in their plans if at all possible.

As Table 6 shows, the family income was related to the family attitude toward the patient's illness. Families making less than \$2,000 per year in most cases felt the patient's illness was curable. Only one-half of the families making over \$2,000 per year felt the illness was curable. However, the poorest families (under \$2,000 yearly) did not markedly favor release. Living arrangements were also associated with family attitudes. The availability of a room at home for the patient correlated with a belief in curability and an interest in release.

DISCUSSION

The aim of the present report has been to examine the family as a potential resource in the rehabilitation of the chronic schizophrenic patient. Many of these patients have functioned successfully in a custodial hospital environment. This level of functioning might extend to some increased interaction with the community. Yet the nature of the disability prevents these patients from initiating contact with the community. We find that the primary potential community resource available to the patient is his family.

A striking finding of this study is that families continue to visit the patient, even after he has been continuously hospitalized for a minimum of five years. This interest persists despite a lack of or the unavailability of many family members. Apparently one should not underestimate the strength of family ties, even after prolonged separation. The nature of this family bond

and to what extent it involves affection, guilt or other feelings need further investigation.

Contrary to our expectations, the patient's age had no bearing on the frequency of the family's visits. One reason for this may be the limited age-range of our sample (25-50 years). The greater interest and optimism of the families of women patients were expressed in more frequent visits. This may be due to the fact that these families did not express fears of aggressive acts. Therefore, because they were less frightened about their sick relative, they were freer to think of the possibility of release. Also, families of female patients may have been more optimistic about release because they thought that the patient could help the family with the housework, baby sitting, etc. This finding that no families expected female patients to provide financial assistance might suggest a different approach in the rehabilitation of these patients. It is possible that their rehabilitation might be oriented more toward the home, and that the rehabilitation of male patients might be oriented more toward a job situation.

Families, however, were limited in the amount of assistance they could offer the patients. The income of these families was very low at the time of transfer. This finding is in accord with Hollingshead and Redlich⁷ who have indicated that many chronic schizophrenic patients come from families of substandard income. Many families did not have room for the patient, nor could they help the patient get a job in the community. Again, because of low income, nine, or slightly under one-half of the families, did not have extra living arrangements, nor did they have businesses which could incorporate the patient.

The attitudes of the families were related to their income. The lower-income families

⁷ Hollingshead, August B. and Frederick C. Redlich, *Social Class and Mental Illness: A Community Study*. New York, Wiley, 1958.

were more optimistic about their relatives' chances for recovery. Possibly these same families might be more tolerant and they might be less sophisticated about mental illness and less self-conscious about amalgamating the chronic patient into their social milieu. These families favored release more often than the higher-income families. This finding might indicate that the family with limited circumstances is not pressured by the hospital to assume more responsibility in the rehabilitation of the patient. The limited expectation of the family in regard to release often appeared to differ from the expectations of the hospital staff, which is inclined to expect more independent behavior from patients considered for discharge.

The realistic limitations of many families of the schizophrenic patients suggest several avenues of assistance. The psychiatric social worker's continuing contact might enable the family to deal more effectively with the problems of chronic schizophrenia. The worker might assist the family in making better use of community resources. There is, however, an increased need for expanding these resources to include further financial aid to the family, increased use of family-care programs,⁸ more half-way houses⁹ and sheltered workshops. Perhaps even more important is the need for a positive attitude towards the possibilities of increased social effectiveness of the chronic patient by the psychiatric social worker on the hospital staff, by social workers in community agencies and by the community.

SUMMARY

Twenty-four families of chronic schizophrenic patients undergoing treatment with drug and social therapies were studied to determine their potential role in the patient's rehabilitation and discharge.

Many of these families continued to maintain an active interest in the patients. This interest was expressed in continuing visits to the hospital and hope for possible recovery and discharge. Their interest was limited by a significant lack of available family members. The family's contribution to rehabilitation and discharge was complicated by financial insecurity, insufficient room at home for another family member, inability to help the patient find a job and lack of social resources.

The importance of the increased use of the psychiatric social worker as well as additional community resources was emphasized.

ACKNOWLEDGMENTS

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⁸ Crutcher, Hester, *Foster Home Care for Mental Patients*. New York, Commonwealth Fund, 1944.

⁹ Huseeth, Brete, "Half-Way Houses: A Review of Factors Crucial to Their Effective Functioning," excerpted in *Mental Hospitals*, 9:8(1958), 5-9.

HUGH G. WATTS
JOHN M. DAVIS

Attitudes toward psychiatry

It is felt that more mental patients could be helped if the psychiatrists could make their initial contact with the patients earlier in the course of the disease. It is important, therefore, to have a sound understanding of the factors which deter people from seeking psychiatric aid when they are in need of it. The importance of this problem is illustrated by the work of Cole,¹ who found that of 111 persons found to be mentally ill in a random survey of 200 Salt

Lake City families, only 13 received psychiatric treatment—in spite of the fact that 61 recognized that they were mentally ill.

For the success of a mental health program, it becomes important to understand the attitudes which people have toward psychiatry and how they contribute to keeping the mentally ill from the psychiatrist. From this knowledge it may become possible to learn how best to alter these attitudes.

The university campus provides a small and convenient community where attitudes toward psychiatry can be studied. The problems of early diagnosis and treatment are of special importance in this situation where stresses are frequent and acute, and the problems are usually more amenable to early psychotherapy provided that the students are willing to accept it. Work by Meyer² indicates that the public seems ready to accept guidance and education in the field of mental health. Certainly, it

When this paper was submitted early in 1959, Mr. Watts was a third-year student at Harvard Medical School and Mr. Davis a third-year student at Yale Medical School.

¹ Cole, N. J., C. H. H. Branch and P. M. Shaw, "Mental Illness—A Survey Assessment of Community Rates, Attitudes and Adjustments," *AMA Archives of Neurology and Psychiatry*, 77(April 1957), 393-98.

² Meyer, R. C., "Is the Public Ready to Fight Mental Illness?" New Jersey Department of Institutions and Agencies, 1955.

would seem that college students, subjected to psychology courses and reading matter in related fields, would be even more ready to accept mental health programs into their communities. However, we shall present evidence which indicates that among most of the college students we studied such attitudes of acceptance are largely superficial and that further questioning exposes a basic mistrust of psychiatry.

METHOD

This survey was conducted at a private, all-male eastern university. The sample was composed of 150 undergraduates whose names had been chosen at random from the student directory. Of this sample 10 students could not be seen because of schedule conflicts. The remaining 140 students represented approximately 5% of the undergraduate population. These students were subjected to an interview consisting of 15 sections, each in several parts, as an attempt to elucidate:

- Their attitudes toward counseling in college.
- What they knew about existing psychiatric and counseling facilities.
- Their attitudes toward college psychiatrists.
- Where they would take their problems when they had them.

- What types of problems they felt ought to be dealt with by the psychiatrist and by other men who, by their frequent contact with students (faculty, dean, chaplains, etc.), are in a position to help.

These data are excerpted from a larger study of the effectiveness of the mental health program established at this university.

RESULTS

When the students were asked "What is your attitude toward counseling in college?" 22% of them answered "very favorable," 70% answered "favorable," 6% answered "unfavorable" and 2% "very unfavorable." (See Table 1.)

When these same students were asked "When do you think that it is justifiable to seek help?" 30% replied "anytime," 59% answered "as a last resort" and the remaining 11% answered that it "depended on the individual," "depends on the problem," and "for aptitude information only." (See Table 2.)

The undergraduates were asked to list the various people and places where a student could go for counseling. Although most students thought of the faculty and the chaplains, only 20% (27) thought to list the university psychiatrist. This result had been suspected from pilot study work,

TABLE 1

Student responses to the question "What is your attitude toward counseling in college?"

	PER CENT OF STUDENTS	NUMBER OF STUDENTS
Very favorable	22%	31
Favorable	70%	98
Unfavorable	6%	8
Very unfavorable	2%	3
Total	100%	140

TABLE 2

Student responses to the question "When do you think that it is justifiable to seek help?"

	PER CENT OF STUDENTS	NUMBER OF STUDENTS
Any time	30%	42
As a last resort	59%	83
Miscellaneous	11%	15
Total	100%	140

so a question had been added to determine whether this low figure of 20% represented personal feelings about psychiatry or ignorance of the existence of the psychiatrist. The students were asked "Were you aware, before this interview, that there was a university psychiatrist?" Considering the suggestibility of the question, it is surprising to find that only 30% of the respondents answered "Yes." (See Table 3.)

The question was asked of the students "If you had a serious problem, would you hesitate to go to the psychiatrist?" The answer, "Yes, I would hesitate," was given by 56%. (See Table 4.) To "Why?" the answers were fairly evenly distributed among "Would work out own solution," "Don't know anything about this particular psychiatrist," "Don't know anything about psychiatry," "Depends on the problem," "For religious reasons," "Just don't like the idea," "Psychiatry is no good," and a few miscellaneous answers.

The students were asked what they them-

selves would do if faced with a problem when they found that they could not reach a satisfactory solution on their own. A set of 11 hypothetical situations was given (for example, "You have no incentive to study and are getting seriously behind in your work, but you cannot do anything about it," "You seriously feel that the whole world seems to be against you," "You are considering dropping out because you feel that you are not getting enough out of this university," "You feel that you are being pushed or are drifting into a marriage that you are not sure you want.").

With the exception of two very specific questions about difficulties with inadequate reading ability and about the choice of a major field of study, on each of the remaining nine questions an average of 14% of the respondents said they would "do nothing."

On the problems that would be considered to be in the realm of the psychiatrist, only 11% (15) said that they would go and

TABLE 3

Student responses to the question "Were you aware, before this interview, that there was a university psychiatrist?"

	PER CENT OF STUDENTS	NUMBER OF STUDENTS
Yes	30%	42
No	70%	98
Total	100%	140

TABLE 4

Student responses to the question "If you had a serious problem, would you hesitate to go to the psychiatrist?"

	PER CENT OF STUDENTS	NUMBER OF STUDENTS
Yes	56%	78
No	44%	62
Total	100%	140

see him. On these problems 13% (18) said that they would talk it over with their roommates or fellow undergraduates.

To determine the types of problems which the students felt ought to be handled by the various men in the academic community who involve themselves with mental health, the respondents were given another set of 10 problems similar to the examples given above. They were then asked, not where they themselves would take these problems, but where any undergraduate could take the problems. The question was worded so as to eliminate subjective feelings that a respondent might have against any group or individual. For example, a student who had no religious affiliation would probably not take certain problems to one of the chaplains, but he would realize that other students might very well do so.

If the number of respondents who stated that a particular group or individual could possibly help a person with that problem is subtracted from the total number of respondents, it is possible to estimate what percentage of the students perceived that group or individual as not handling that type of problem. For example, if the problem had to do with the choice of a major field of study and only 10% of the 140 respondents feel that undergraduates would take such a question to their parents, then 90% of the respondents perceive the parents as not handling such a problem.

By this method 36% (50) of the students perceive the psychiatrist as not handling a problem such as "Feel extremely depressed, and that the world has lost its meaning." The faculty were not perceived as handling personal problems by 65% (91) of the students.

DISCUSSION

There appears to be a highly ambivalent feeling toward psychiatric counseling in college. On the one hand, most students approve of it and feel that it is a necessary part of the college. As stated above, some of this approval probably stems from an increase in knowledge of the field due to the popularity of the psychology courses in personality theory and in abnormal psychology at this university. The increase in literature on the subject and the prominence which this topic enjoys at the whims of current motion picture fashions have undoubtedly contributed to this attitude. However, this approval appears to be largely on the intellectual level, for there seem to be underlying negative feelings toward psychiatry: (1) it is felt that psychiatry is something which should be turned to only as a last resort; (2) few of our respondents would see a psychiatrist if they had a psychiatric problem and many would do nothing; (3) most were ignorant of the existing psychiatric facilities; (4) most did not perceive psychiatrists as giving help on some psychiatric problems.

It appears that a common source for these feelings is a general misunderstanding of the counseling situation, in that many students feel that in seeking help they are transferring the burden of the problem onto the therapist, thereby absolving themselves from responsibility. A member of the faculty remarked that he had noted a tradition among the students that a boy should face all situations by himself in order to prove his maturity. Thus it may be that the students fear any intensive mental health program which might label them as "pampered" or "mollycoddled."

Our findings showed that on many psychiatric problems, about 20% of the respondents said that they would "do nothing," while Cole found that when his subjects were given a hypothetical example of a disturbed neighbor 41.7% said that they would either do nothing or advise the neighbor to take a trip, join a club or get out more often. Thus, the denial of a problem appears to be a common reaction to mental illness.

The lack of knowledge among 70% of the respondents that psychiatric help had been available to the students may represent a lack of extensive publicity on the part of the university, or may be in some way tied in with the students' ambivalent feelings about psychiatry. This ignorance of psychiatric facilities was also found in the Salt Lake City study, where 61.1% of the respondents knew of no local psychiatrist in spite of the existence of an energetic educational campaign in the area. This remarkable ignorance may possibly suggest an element of resistance.

Our figure that 11% of our sample said that they would go to see a psychiatrist if they had a psychiatric problem is comparable with the Salt Lake City study finding that of the 111 persons found to be mentally ill, 11.6% (13) were under psychiatric

treatment. Our confirmation of Cole's findings is remarkable in view of the differences between the two populations studied—Salt Lake City, a mecca of the Mormons; and an Ivy League university, a mecca of Joe College.

The verbalized hesitancy of these students to seek psychiatric help when in need of it, and their perception of the psychiatrist as not dealing with many of the personal problems of students is perhaps surprising. It indicates that the educational programs which have been promoting mental health and the intelligent use of psychiatric therapy seem to have failed to penetrate all but the surface—and this among the members of a highly educated group. Such discouraging results might suggest the need for some new educational approach, or at least more sound information about the attitudes of the people at which the educational programs are being directed.

SUMMARY

A random sample of 140 college undergraduates were interviewed to determine their attitudes toward psychiatric and other forms of counseling at the college. It was found that:

1. Their attitudes toward counseling appear to be ambivalent. They encourage counseling in the abstract but are fearful of it in its concrete forms.
2. A large number of students were found to be unaware that the facilities of a university psychiatrist were available to them.
3. A majority of students stated that they were very hesitant to use the services of a psychiatrist and even then would do so only as a last resort.
4. The students did not perceive the psychiatrist as being able to help them with many of their personal problems.

JOSEPH C. SOLOMON, M.D.

Neuroses of school teachers

A colloquy

The schoolroom must be looked upon as a force secondary in importance only to the home in the development of human personality. Psychopathology which may have originated in the home can be crystallized or fortified in the school situation. A child with both stable parents and stable teachers is fortunate. Conversely, emotional problems are aggravated when a child with unstable parents is exposed to unstable teachers.

Parental attitudes are known to be largely responsible for both healthy and disturbed emotional development. It is common knowledge that many behavior problems of children reflect the unconscious conflicts of one or both parents. It is therefore perhaps important to examine the possible effects of unconscious conflicts in teachers as they may affect the emotional development and especially the learning of their pupils.

These attitudes of hostility, indifference, excessive sympathy, seductiveness or indulgence represent, for the most part, unresolved problems within the teacher and need to be understood for effective teaching.

Relationships between teachers and pupils are most significant in the early years, just as they are in parent-child relationships.

Blocking and disability in certain areas of learning may be attributed to poor

Dr. Solomon, who is a practicing psychoanalyst and an associate clinical professor of psychiatry at the University of California Medical School, read this paper May 13, 1958 in San Francisco at the annual meeting of the American Psychiatric Association. At the same time Dr. Norman E. Zinberg, associated with the late Dr. Leo Berman in his well-known program with Boston school teachers, gave an extemporaneous description of their project that is not part of the published colloquy.

teacher-pupil relationships or may be a screen for other difficulties in the parent-child relationships. However, the crystallization or malintegration of particular patterns may have received the final push from a disturbing school situation in a predisposed child.

The teacher's understanding of his or her own emotional make-up and attitudes to all or particular pupils is important. What we hope to bring out in this presentation is the concept that the classroom can furnish an atmosphere where there is stable leadership and where the emotional interactions between teacher and pupil are understood and handled in such a way as to aid the student's emotional growth and enhance his learning. We also wish to recognize that as a whole teachers are a relatively stable group of individuals, certainly as stable as any other profession. The great stresses and strains to which they are subjected come not only from pupils' problems but from parents, school administrators and boards of education.

Dr. Berlin, who has had considerable experience as a consulting psychiatrist to schools, will continue the discussion.

FROM TEACHERS' PROBLEMS TO PROBLEM TEACHERS

By I. N. Berlin, M.D.¹

Eight years of psychiatric consultation with several school systems has convinced me that most problem teachers have resulted from certain pressures and practices which seem inherent in many school systems. I have rarely seen a teacher in consultation whose difficulties resulted only from her own personality problems. I have many

times worked with teachers whose evident character disorders would seem to preclude their effectiveness as teachers, and yet with wise management and assistance from alert, intuitive administrators these disturbed teachers were doing good jobs in the classrooms. Other psychiatric consultants have confirmed my impressions that neurotic disturbances among teachers are not more frequent than those found in other professions that work with people. Problem teachers seem to result from the same juxtaposition of forces which make for neurotic disability in all human beings—namely, the severity of the stresses, their duration and the susceptibility or predisposition of the individual.

I have felt that the stresses which impinge on the teacher can be divided into two large categories—the external stresses and the internalized ones.

The external stresses are becoming more and more severe. They seem to be unremitting and pose serious problems for the mental health of even the most stable teachers. These increasing stresses result from the ever-larger numbers of children with little motivation to learn, little curiosity in the world about them and very little ability to derive satisfaction from working or mastering a task. Thus, teachers are being faced in their classrooms with growing numbers of indifferent children. They have little desire to learn to read, or to learn at all.

With these ever-larger groups of non-readers and nonlearners come the resulting increase in behavior problems. Since there are few if any satisfactions from learning for these children, and since they have not been helped by their parents to learn to master environmental problems by regular, continued and steady effort, these children feel constantly dissatisfied, disgruntled and tense. These feelings are expressed in

¹ Dr. Berlin is in the psychiatry department of the University of California School of Medicine, and the children's service of the Langley Porter Neuro-psychiatric Institute, San Francisco.

acting out, aggressive, hostile, tantrum behavior.

Such disruptive behavior occupies more and more of the teacher's time. She has less and less time to teach the few children who want to learn. The teacher's satisfactions from teaching are consequently being continually reduced. Added to these stresses are the unreal demands of both school administrations and the communities

In the face of these growing problems many school administrators have been demanding that teachers counsel disturbed children and their parents. Thus, to the burdens of attempting to teach unwilling pupils are added the burdens of attempting to counsel troubled parents and children whose hopeless and helpless feelings are often manifested in hostile, defiant, indifferent and demanding attitudes.

The teacher is therefore doubly frustrated and defeated. She is not trained in psychotherapeutic techniques, her efforts to help disturbed children and their parents often backfires and even skilled, well-adjusted teachers begin to feel helpless and ineffectual.

From many communities there are increasing demands, tacitly accepted by some school administrators, that it is the school's job to instill discipline, the desire to learn, cooperative interpersonal attitudes, respect for authority, good work habits, etc. Many parents in our society seem to be desperately looking to others, since they seem unable to look to themselves to exercise the parental roles. Under such pressures more school administrations accept these assigned roles. The evidence accumulated in the last few years is quite clear. It is extremely difficult, if not impossible except in rare individual instances, for teachers to assume the parental responsibilities. The educator faces an almost impossible task

with those children who have not been helped to enjoy learning, to delight in the quest for knowledge and to feel the satisfactions that come from mastery of self and the environment.

The pathetic paradox is that all of these increasing demands and expectations are placed on the shoulders of teachers who are ill-paid and yet expected to unselfishly devote all their time to work which not only has little monetary reward but carries ever-fewer satisfactions in actual teaching.

In addition to these external stresses teachers are subject to traditional indoctrination in most teachers' colleges which tends to deny the teacher the right to feel and to express human feelings. Teacher trainees usually are given to understand by their instructors that good teachers feel only love and compassion for their students, and that no matter what the provocation they must never feel hostile, angry, frustrated and hopeless. Teachers who find themselves in difficult teaching situations often feel they have nowhere to turn, no one to whom they can ventilate and relieve themselves of the burdens of suppressed feelings. How often I've heard administrators say, "We just don't get angry. We help all our children with love and patience, don't we?"—this to a teacher beside herself with tension and fury because her best efforts have been thwarted by an indifferent, defiant student. In many schools a teacher knows that any admission of how she feels will cause her to be labeled a poor teacher. In my own experience this burden alone has caused teachers to feel that the strains of teaching were too difficult to endure, and they have consequently left teaching.

Thus, there are increasing demands on teachers to instruct more and more unwilling, rebellious pupils. In addition, they are expected to take over not only the

parental job towards the children but in many instances to be parents to the parents, or at least to be their psychotherapists. Finally, there are the unreal internal stresses which deny teachers the recognition that their feelings in difficult classroom situations are human, acceptable and must be ventilated and communicated to others for their mental health.

All these teachers' problems tend to make for problem teachers.

The problem teacher is usually one whose psychological makeup results in a particular equilibrium necessary for his functioning but often maladaptive and discordant in the school setting.

As I have tried to understand the problems of the teachers with whom I have worked, I have come to feel that those with learning problems of their own seem to react to stress with the most maladaptive behavior. I have no way of knowing the frequency with which these particular patterns occur in schools.

I have been most interested in these problem teachers who appear to derive little satisfaction from learning. Since they themselves have not acquired the capacity to obtain pleasure and satisfaction from learning, from working effectively and mastering their job, they seem to be especially vulnerable to situations where their students manifest similar problems of the same or greater severity. Thus, they are caught in the dilemma of trying to help others do what they themselves cannot do. Many of them turned to education in the hope that they could get by with little effort or knowledge, only to find themselves increasingly disorganized, harried, frantic and unable to control their classes. If the administrator tries to help by making the job easier, by expecting less of the teacher or doing some of it for the teacher, the problems usually are compounded.

These teachers tend to regress the more their work is done for them. They are most difficult for administrators, and I feel they are their most troublesome problems.

For such teachers classroom control is extremely difficult. They often lose their tempers and resort to corporal punishment in a desperate effort to maintain some control of their pupils. The substitution of force for teaching skills and knowledge occurs frequently with these teachers and presents recurrent problems to the administrator.

Certainly any severe neurotic conflicts which reduce the teacher's feelings of self-esteem and worth will result in teaching problems. These may be seen either in overindulgent seductive behavior or punitive harsh actions with pupils. Both extremes are designed to maintain control of their pupils in the face of the violent internal conflicts.

I've been repeatedly impressed with how those administrators who focus on the job of teaching to be done are able to reverse the process from problem teachers to teachers' problems. Their ability to listen to teachers with concern and to expect and insist on a good job of teaching has helped teachers to work more effectively to their own increased satisfaction. In turn, as teachers do more teaching they begin to expect more learning from their students.

When administrators have been helped to delineate their own capacities and limitations as human beings and to accept their own feelings in face of problems and frustrations, they have sometimes adopted more realistic attitudes about the role of the schools. Thus, the administrator is able to maintain that the school's chief role is imparting knowledge and techniques for acquiring knowledge. He helps his faculty to see their role as one of teaching and not

being substitute parents. Then also the human emotions of administrators, teachers and pupils are accepted and allowed ventilation, and more teaching and learning occurs.

In one school, following repeated psychiatric consultation, parent-teacher-administrator conferences were held around each problem child as frequently as possible. In each conference an effort was made to delineate the role of the school and the parents. There were many initial angry protests by the parents. They clamored that the school was failing in its responsibilities to the community. However, later in the year some of these parents in their P.T.A. meetings expressed their appreciation that they were being helped to be more parental with their children. Some parents volunteered that their children were now learning more. Some were beginning to learn for the first time.

I am impressed that the equation from teachers' problems to problem teachers is a reversible one.

Dr. Solomon: It is an interesting commentary that some teachers seem to have a consistently high percentage of problem children and others do not seem to have any. This is similar to the recently disclosed fact that some capable physicians consistently run into malpractice suits and others, who may even be less skillful technically, are never sued. The answer lies in the stability and leadership qualities of the individual doctors.

The classroom situation provides an ideal opportunity to exercise leadership. Principles of group leadership can be applied in the school setting. We do not imply that teachers need to be skilled group psychotherapists, but some of the basic principles can bear elucidation. Dr. Lind-

gren will take up the discussion from this aspect.

PEDAGOGY AND GROUP LEADERSHIP

By Henry Clay Lindgren, Ph.D.²

Both psychiatry and teaching have a common interest in promoting emotional maturity, although teachers differ both from psychiatrists and among each other in the way in which they view the roles appropriate to this function. Both psychiatry and teaching are concerned with helping people learn new ways of coping with the world and its realities. Teachers and psychiatrists alike are regarded as authority figures. The teacher, however, has a dual task. He must be concerned with individuals, but if he is to be really effective in his work he must always keep the group in mind. Most of his planning and presentation is done in terms of the classroom group. Teaching a group of 30 students is not just a matter of teaching 30 individuals—it is also a matter of teaching a *group* of 30. Many a teacher has found that he has one kind of relationship when he works with a child alone and a totally different kind of relationship when the child is with the classroom group. Often the child behaves in one way when in the classroom group and in an entirely different way when alone with the teacher. Some teachers are disturbed by this and do everything they can to keep a group relationship from developing in their classes so that they can maintain a person-to-person relationship with each student. Some teachers will tolerate the group as a group only on their own terms—that is, only if it will be completely subservient to the

² Dr. Lindgren is professor of psychology at San Francisco State College.

teacher's will. And of course other teachers accept the group and use its dynamics as an aid in teaching.

There are an infinite number of problems that teachers face in attempting to work with the groups and individuals in their classrooms. I wish to first discuss the conflict between autocratic and democratic modes. As the world moves toward greater democracy, we see less and less emphasis on methods based on force, coercion, and reward and punishment, and more emphasis on permissiveness, cooperation, tolerance and mutual respect.

One of the difficulties resulting from this change is that our ideals get ahead of our methods. This means that our desire to deal with children democratically is frustrated by the fact that we have not developed methods and approaches that are consistent with this philosophy. This conflict between philosophy and methodology obviously creates a number of perplexing problems. Many teachers deal with this conflict by using autocratic methods in the firm belief that they are being democratic. A teacher once told me, without any thought of inconsistency: "I run my class democratically. At the beginning of the school term I write the rules of behavior on the board and the whole class votes to abide by them." A few teachers deal with the problem by abandoning controls altogether, in the mistaken belief that democracy is equivalent to absence of authority. Still other teachers continue to use a mixture of democratic and autocratic methods but are continually bothered by the gap between their ideals and their behavior.

One solution to this problem may be found in the mutual respect of teacher and pupil. The teacher needs to respect himself and his pupil as persons who have a right to be valued and appreciated, as per-

sons who are not to be exploited, despised or victimized. From the standpoint of leadership, it can be stated that unless a teacher respects both himself and his students, he cannot realistically expect them to respect him or themselves.

The second problem is the matter of the role played by the teacher in the mind of the child. By tradition and by law the teacher is *in loco parentis*—in place of the parent. The assumption of a parental role can be useful if the student's attitude is a positive one—that is, if he has been able to learn from his parents. Many teachers consciously or unconsciously play a role that is very strongly parental in order to evoke and intensify this kind of relationship.

The problem of the teacher's becoming too emotionally involved with her students has both specific and general phases. Probably most teachers enjoy some aspects of their parental roles. The institution of the "teacher's pet" is an extension of this attitude. Every teacher finds that he likes some students better than others; it is difficult to keep from liking the student who is responsive and eager, just as it is difficult to keep from disliking the student who is bored, insolent or rebellious. Needless to say, teachers who are unable to keep these feelings under reasonable control inevitably encounter difficulties. The teacher who openly favors some students and rejects others creates resentment and hostility—both disintegrative forces within the classroom group. Under such conditions learning becomes difficult or impossible. The teacher may be forced to resort to authoritarian methods which can stifle the student's will to learn, or become so protective that the learning situation is neglected.

A general problem relates to the expectations teachers have with regard to students.

A study of teacher-student attitudes in the secondary schools of Newton, Mass., turned up the fact that the teachers were concerned with maintaining friendly relations with students, whereas the students were not concerned with the teachers' friendship. Thus we have the picture of the teacher looking to students as a source of love and appreciation and being rather chronically disappointed. It is easy to see how the student who shows any warmth toward the teacher becomes a candidate for the role of "teacher's pet."

Teaching is the most exposed of all professions: everyone knows how to educate, except possibly teachers. The public tends to see teaching as a matter of knowing your subject. The need for teaching skill is ignored or derogated, and the understanding of the dynamics of human behavior does not even enter the public's awareness as an important factor. The teaching profession is actively discouraged from making use of research findings in modifying existing curriculum methodology. The educational profession is forced to accept an interference in its areas of technical competence that is tolerated by the members of no other profession.

The public's treatment of teachers has had two kinds of results that are clinically interesting: an increase in anxiety and an undermining of self-respect.

The teacher is like a rat in a maze, each pathway of which is triggered to release an electrical discharge. No matter which way the teacher turns, he incurs some anxiety. If he tries to develop an educational program based on educational or psychological research or on a perceptive understanding of students, he may incur public censure and ridicule. His own administrators very often will not defend him under such circumstances. If he chooses instead to use the traditional

methods of autocracy, he fails to stimulate much learning in most of his students. If, as sometimes happens, apathy turns into rebelliousness, he may lose his job for being a poor disciplinarian.

While it may be argued that teaching attracts people who are already neurotically inclined, as one who has been "through the mill" I would like to submit that the strains and stresses to which the teacher must submit are hardly calculated to insure good mental health.

A certain minimum of anxiety is undoubtedly a good thing. It keeps us on our toes and alert. A good teacher, like any other kind of effective leader, needs to learn how to tolerate some anxiety. But when a situation generates more anxiety than can be comfortably handled, the result is far from healthy. One result of a superabundance of anxiety is a narrowing of the perceptual field; the anxious individual is inhibited from finding ingenious and creative solutions to the problems that face him and is forced to fall back on less adequate techniques. He becomes defensive and intensely self-concerned, attitudes inconsistent with effective pedagogy or group leadership.

A teacher who behaves in ways that are defensive, self-concerned or generally ineffectual is not likely to be perceived by his students as richly endowed with self-respect. Nor is he inclined to develop much respect for himself if the public's esteem for him is measured by his salary.

Let us not forget that students, too, are members of the general public. And if they learn outside the classrooms to depreciate their teachers, where can the teacher begin to develop the kind of mutual respect that is essential to good pedagogy or to effective learning?

Teachers are better educated than they used to be. They are widely traveled; few

professional groups know the world as well as they do. They tend to have a breadth of interest and are much more inclined to become involved in the life of the community than they were a generation or so ago.

But their chief source of strength is their interest in their work. Teachers are, by and large, dedicated people. They believe in what they are trying to do. Although their morale has been shaken to some extent by the largely unjustified criticism that has been directed at their profession, most of them continue to bring enlightenment to the young and to take satisfaction in their very real successes. I think it is their ability to find satisfaction in their work that enables them to tolerate as well as they do the pressure and tensions that they encounter in their profession.

Dr. Solomon: As a leader, the teacher becomes an accessory parent. In the lower grades he or she may represent a real parent figure with some of the parent's inherent duties and obligations. When the child's needs have been met adequately at home the parent role of the teacher is quite secondary. But the child may seek collection of an unpaid bill from the teacher when his needs have been unmet at home.

In the classroom situation a good teacher strikes a happy balance between satisfying the needs of the child and expecting co-operation and good work. Such a teacher is revered and remembered as a real person who not only imparted knowledge but played a role in the emotional growth of the child.

When there are distortions in the child's ego development or when there are disturb-

ances in the leadership or integrative capacities of the teacher, distorted relationships take place. A good teacher may find reactions in a pupil which are uncalled for by anything that has happened in the classroom. Children may react to the teacher in a way they would like to or actually do to their real parents by hostile attitudes or clinging dependency. This is, of course, the transference phenomenon familiar to all psychiatrists. Emotions that have been invested in other pertinent life figures are transferred to another person.

Teachers may reflect their unresolved childhood problems by unwarranted reactions to specific pupils. Unfriendly attitudes or extreme attachments towards specific pupils may reflect the emotional needs of the teacher. These responses may be provoked by the pupil's own transference reactions. For this reason the term countertransference is employed.

Dr. Baruch will take up the discussion of the phenomena of transference and countertransference.

TRANSFERENCE AND COUNTER-TRANSFERENCE IN THE CLASSROOM

By Dorothy W. Baruch, Ph.D.³

Many definitions of transference and even more varied ones of countertransference exist in the literature.

Freud stated, "The patient puts the analyst in place of his father or mother. Thus he becomes a new superego [which] now has an opportunity to correct blunders."

We could parallel this in the school situation and say with equal validity that "the child puts the teacher in place of his father or mother" and that the teacher similarly has the opportunity of correcting emotional blunders, at least where blunders have not been too traumatic and where

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the child has not grown too disturbed. Here the teacher's own emotional reactions, his countertransference, enters. His feelings, derived from his past, play their part. In teachers there are countertransference derivatives that might be expressed as "I have to be the ideal parent in my relationships with these children." As long as the teacher can be the ideal parent, sweet and calm, gracious and giving in gesture, and as long as the children remain "little dolls," the picture fits in, moreover, with what the edicts in teacher-training usually claim a fine classroom atmosphere should be like. The transference-countertransference interactions then stay positive.

But obviously many emotional cross-currents interfere. In bringing you some of these I shall draw on experience I have had with teachers over the last quarter of a century both in teacher-training and in group and individual psychotherapy. I shall quote mainly from tape-recorded sessions of a teachers' workshop that has been in process since March 1954, in which teachers from kindergarten through high school have dealt particularly with children's feelings and their own.

The most frequently disturbing pattern of transference-countertransference interaction that we have seen accrues when children act out hostility—indirectly and unavowed—through disobedience, inattentiveness, not turning in assignments or turning them in "messed up" or late, through whispering, quarreling, "goofing off" and "horsing around."

In some instances the situation gets out of hand because in the attempts to maintain an ego-ideal of the "giving" parent the teacher unconsciously wishes to overthrow the introjected, authoritarian, demanding parent. And so, he or she fails to provide the firm leadership that children need. Says a first-grade teacher, "I

feel like a witch when I'm strict. I keep backing down then and the children invariably take advantage." Says a sixth-grade teacher with greater insight, "I had a big struggle with myself in working out where strength was good and where strength was bad, and where I was being like a bad mother and where I needed to be strong. And I came to see that what I had thought was punitive really wasn't. It was actually sticking to needed rules. Since I worked it out for myself, my children work much better."

Sometimes too great permissiveness appears to be a defense against a teacher's revealing hostilities toward actually demanding objects in his past. To quote one teacher, "The children loom up like 37 monsters, each yakking as loud as my mother did." "Demands, demands," says another. "I feel as if they're beating me with their demands and that I have to keep on sweetly saying 'Yes.'"

On the opposite side, some teachers carry out in the classroom the same sort of thing that we have seen youngsters depict in paintings where they draw themselves as gigantic figures beating or smearing their parents, whom they draw very small. Such teachers make the children into parent figures shrunken into nonthreatening dimensions. They carp and criticize and use the children in one way or another as objects of their own ancient hostilities.

As a flagrant example of a teacher's taking hostility out on children, a fifth-grade male teacher read a story to his classroom in which a Corsican boy accepted bribes from a thief, which so offended his father's pride that the father shot the son. Totally unconscious of the sadism involved in the story, this teacher avowed that he read it "just to have a little fun. I like to see their reactions." My workshop members questioned his motives, and during the dis-

cussion that ensued he came out with "My own frustrations have always overwhelmed me." Meanwhile, his rigid classroom discipline and sadism had led his pupils to displace their aggression onto each other. "Someone is always beating someone else up as they come in the door." Concomitantly the achievement level in this teacher's classes was consistently low.

A man teaching the fourth grade has all his life "been in revolt." He permits pandemonium in his classroom. He says, "I think a certain amount of naughtiness in children is desirable." But he lets it get too extreme and then has to "use the paddle, which," he says, "relieves us all." Thus in the countertransference he acts out; he lets the children be naughty and then he gains restitution by punishing them as representatives of his guilty self.

Occasionally a teacher appears to take children as siblings. A high school teacher, for instance, finds herself "picking on" a particular popular girl. "My sister was glamorous; I wasn't" shed light on the matter when it slipped out one day. Another teacher, who had had numerous younger siblings to care for, continuously complained that "the children weigh me down."

In contrast, we have worked intensively on how the transference-countertransference interactions can be used as assets in the school situation. We include such qualities as understanding and acceptance—of feeling "with" a child because within oneself one knows how he feels. It enables the teacher to react in positive fashion to transferences from the child.

We have found that it helps to make the countertransference positive when the teacher can see that often children want from him what they have emotionally wanted at home. It helps the teacher to see that often transference behavior at-

tempts to elicit attitudes that the individual has not had at home. What we have found helps most, however, is for the teacher to recognize that children transfer onto him their negative and hostile feelings towards their parents. This often relieves the teacher of unrealistic guilt, self-condemnation and a needless sense of failure.

In short, meaningful awareness of the psychodynamics of childhood and how children bring a multitude of feelings from home into school often enables the teacher to give to the children, in ways appropriate to the school setting, adaptations of what Franz Alexander has called the "corrective emotional experience."

Teachers are helped, too, to make such adaptations when the difference between indiscriminate acting out and "channeling" of feelings is clarified.

In a B-11 United States history class—that is, with 15 and 16-year-olds—the subject of freedom was being discussed. There were muttered swear words, throwing of erasers, sly passing of notes, general disorder. These the teacher recognized, to quote his own words, "not as an affront to me, as I might have formerly. But I knew they were mad. And I thought: Better get it out legitimately. So I said, 'You seem bothered and mad at me or at somebody in connection with this business of freedom. Suppose you write out how you really do feel. Anything goes in the writing. But no more swearing, etc. Here is a way to get out your anger.'" To give just a simple single sample of the transference evident, I quote in part one boy's paper: "There is supposed to be freedom in the U.S. But the teachers tell me what to do. The principal tells me what to do. We can't talk. We can't be late. We can't chew gum. We can't do anything but our own school work which is terrible.

It's the same at home. The old lady tells me mow the lawn, sweep the patio, do this, do that. The old man comes home. 'You forgot to do this. You forgot to do that. Leave your car in the garage and walk to school.' And there it starts all over."

To skip down to lower levels, a number of teachers have given children chances to bring out how they feel about their polio shots. In one kindergarten several children made clay mothers and clay teachers and "mashed them up cause they hadn't ought to let the doctor to it," showing mother and teacher taken as one. (Incidentally, at all elementary levels teachers report that children inadvertently address them as "Mother" or "Father," "Mommy" or "Dad.")

In another kindergarten a little boy persistently buried a ball in the sandbox, kicked it and hit it. "I'm spanking you, Mrs. Hall," he announced. The teacher said, "You'd like to do that sometimes." He hit some more, "I'm hitting your husband. I'm angry at your husband." The teacher nodded. "I think maybe you're angrier at somebody else's husband." And he said, "Yes." He was "angry at Mrs. Webster's husband"—his father—and he added, "Angry at Mrs. Webster too. Just like at you." "I know" said the teacher, "All little boys get angry at their mothers and fathers sometimes and want to hit them or hit their teachers instead. They can't really. But they can hit the ball . . . or ?" she turned and questioned the cluster of children who had gathered around. "They can paint hitting pictures," one child volunteered. "Or throw bean-bags," said another. "Like we'd like to do at you sometimes." "But can't."

In handling stress situations between children, it helps also for teachers to realize that derivatives of the sibling relationship are often involved.

Another question current in psychotherapy is also important in the school situation: Shall the therapist—or in this instance the teacher—share countertransference reactions? In the classroom we have come to see that the teacher's verbalization of feelings makes for more positive interactions. We have found that the atmosphere remains more wholesome and the children's work progresses better when teachers are able to share their feelings, not to absolve the venting of anger but as one means of offsetting the necessity to do so.

Children in the classroom acutely perceive how the teacher feels.

In a first grade, for instance, a teacher slammed a book down on her desk, feeling she'd like to slam one of the noisy little children. The children caught it. One said primly, "It's no good for us, Mrs. Allen, when you slam books." Another said more resolutely, "I feel like you're slamming me."

In a mixed grade of elementary school children with hearing disabilities, a teacher found herself feeling very annoyed and abused because the children were not jumping in to help her clean up the paints they had used in a harbor unit. To give her own account: "They sat like little mummies, all staring. No one did anything. Finally I caught myself and I said, 'I'm mad at you.' And Nina said, 'Boy, you *are* mad. I guess you feel like when your mother used to make you do all the work!' She knew! . . . I said, 'Yes.' Then they all started grinning. And boy, they buzzed into it! And we all felt very solid and good."

As a fourth-grade teacher summarized it: "If I say how I feel, the children seem to feel safer. Even though I don't know what it goes back to or why, it's there."

Obviously what we have been talking about here are the conscious derivatives of

the countertransference. In some teachers the unconscious parts may call for far deeper psychiatric help.

Not all teachers, however, can have the benefit of psychotherapy. But all teachers could benefit by having the psychiatrist become one of the important teachers in the education of every teacher today.

Dr. Solomon: It is gratifying to report the growing appreciation and understanding by school teachers of their deep-seated reactions to their pupils. This is demonstrated by the increasing number of teachers who seek psychiatric assistance for their personal problems. A generation ago a teacher would have jeopardized her job and been stigmatized if she had consulted a psychiatrist. If my experience is typical I can say that there are hundreds of teachers who are or have been in some form of psychotherapy. I have learned a great deal about the interactions of teachers with their pupils, administrators and parents from the psychoanalysis of several school teachers.

One teacher reported an especially unfriendly attitude towards one of the boys in her class. She was particularly irked by his aggressiveness towards little girls. He shoved, taunted and molested them in every possible way. The teacher recognized that her hostility was out of propor-

tion to the harm done by the boy. By means of her associations she recognized that she was displacing aggression from a different source onto this boy. Her daughter had a romance with a particularly obnoxious sailor who had first definitely forced his attentions on her and later disappeared. The girl developed a serious mental depression. This situation was fresh in the teacher's mind when she reacted to the boy in her classroom for treating the girls as the sailor had treated her daughter. When she recognized the source of her feelings she was able to deal with this pupil more realistically.

Another teacher said during analysis that her whole classroom attitude had changed. Formerly she had spent a good deal of time insisting that all the desks be exactly in line and everything else compulsively orderly. She was able to relax her unnecessary rigidity. She admitted that she must have made her pupils miserable with her authoritarian demands.

In closing this colloquy let me reiterate the statement made earlier—namely, it is not recommended that teachers become either individual or group psychotherapists but that they learn enough about the reactions of their pupils to themselves and of their unconscious reactions to pupils so that they can teach more effectively.

LEO EITINGER, M.D.

Psychiatric investigations among refugee patients in Norway

With some remarks
on the causal chains
in mental disorders

Ehrenteil (1) introduces his study with Overholser's observation about two separate causal chains which together produce the clinical picture of psychosis. This observation is of importance for all countries which carry on psychiatric research. The swing of the pendulum between somatic and psychologic viewpoints of the cause and treatment of mental diseases was more extreme in some countries than in others. Norway is among those countries where this swing was fairly moderate, a fact which is perhaps due mainly to the influence of Norway's first professor in psychiatry, Ragnar Vogt (11), who formulated his view on the great controversial questions of the period in Adolf Meyer's spirit: "not either-or but both-and." Ehrenteil's demonstration that "one group of causes, the pathologic-physiological, produces the dis-

turbance in mental functioning which allows a break with reality, while another group of causes, the psychodynamic and social motivations, determines the direction which the psychotic deviation will take" is the modern expression of the above-mentioned quotation.

A scientifically valid confirmation of this opinion can best be obtained by investigating large groups of patients in whom one can reasonably expect to find the same psychodynamic and social motivations to see how far they, independent of the pathological-physiological causal chain, show the same symptomatology with regard to the

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direction of the demonstrated psychopathological changes.

The author has carried out an investigation of this nature in connection with a psychiatric estimation of refugee patients in Norway, and has reported this in detail elsewhere (3). In this paper we will merely refer briefly to the data which is pertinent to the matter before us.

"The average refugee population" of Norway was found to consist of 1,789 persons. Of these 60 became psychotic in the observation period (January 1, 1946 to December 31, 1955), which is 3.19% of all refugees. All the patients who at the time of the investigation were still in Norway were personally examined by the author. The observed incidence for all diagnoses was 60 in the refugee population, compared to 11 which could be expected in a corresponding Norwegian population group.

It is a general and almost certain experience, confirmed, among others, by A. Kerenyi, E. K. Koranyi, and G. J. Sarwer-Foner (6), that paranoid reactions and paranoid states are very frequent, and certainly more frequent among refugees than among other population groups. This fact does not warrant any special comment. What proved to be remarkable in the detailed examination of the case histories and the personal investigation was, however, that those patients who could not be classified under these headings also showed massive persecutory traits. This was shown perhaps most clearly in the 4 patients with chronic brain disorders who appeared in the group investigated. The two causal chains could be most easily explained here, and from the case histories it will be seen that both of these were decisive for the completeness of the picture of the illness.

The first patient was a Polish, Roman Catholic laborer, born in 1917. During the first days of the war he had been taken

prisoner by the Germans, and since then he had had to work as a slave laborer in different camps in Germany. In 1943 he had his first epileptic attack and in 1944 his eyesight started to fail. He was not examined by a doctor until after the war and then it was proved that he had a glioma, for which he was operated on in 1946. After the operation he became totally blind (amaurotic), but was otherwise physically fit. He refused to return to Poland, married in one of the camps and lived there without any physical difficulties. Like all other camp inmates, he did no work.

In 1950 he was sent together with other blind persons to Norway with the intention of finding some employment for them. This change of environment in addition to the new demands made on his ability to adjust were too much for the patient. He rapidly became paranoid, thought that his life was in danger, that he was going to be poisoned or killed, and had to be hospitalized. His condition deteriorated considerably in the hospital. He not only suffered from delusions of poisoning but he also thought that his wife, who was not blind, had had him put in the hospital so that she could marry somebody else. He heard his wife and her lover in the room next to his. The doctors, nurses, social worker and so on, were all helping to get the wife married. Everyone was against him, because he was a blind foreigner. At the same time he also showed every sign of organic dementia and died after only three months in the hospital.

The next patient was a 44-year-old Polish Jew, a skilled worker, who had grown up in a quiet and harmonious home under good social conditions and had had an orthodox religious upbringing. During the war he and his family were arrested and both his parents, his siblings, wife and children died. Strangely enough, he him-

self survived, in spite of serious famine edemata, typhoid fever, extreme emaciation and a rheumatic joint disease. After the war he was found to have tuberculosis, and he was treated for this in various sanatoria in Germany. He remarried, but his wife died of tuberculosis only two years after the marriage, and without having had any children.

He was brought to Norway in a tuberculosis transport and admitted to a sanatorium. Here he was the only Jewish patient; there were no Jews in the town near the nursing home either. The official, Protestant public holidays were celebrated in the sanatorium, and there were, moreover, a number of religious events, devotional meetings, visits by priests and so on. The patient soon felt that he had been chosen for conversion by everyone, that they wanted to get rid of him because of his Jewish faith. He was convinced that everybody was talking about him. Finally, he became hallucinated, overheard plans for killing him, thought that a fellow-patient was trying to break into his room one night in order to kill him; he saw the glint of the knife. In wild panic he fled through a window and ran away, clad only in his underwear. On admission to the psychiatric department of the university hospital, he showed, besides these massive paranoid reactions, clear signs of a chronic brain syndrome. He could not remember the most ordinary things (his case history had to be reconstructed on the strength of the information given in his papers), and the psychological tests supported the diagnosis. A pneumoencephalogram showed a dilation of the side ventricles and dilated sulci.

During his stay in the hospital we were able to win the patient's confidence, and the paranoid reactions disappeared completely but the symptoms related to the

chronic brain syndrome showed a negligible improvement only. He was able to be discharged after two months to another tuberculosis sanatorium. However, the same thing was repeated here. In spite of the fact that he was very badly off financially, he would not eat the hospital fare; he said it was poisoned and "what is more, it is not 'kosher'," he preferred to live on rolls that he bought elsewhere. He soon started to think that his life was threatened, and he had to be hospitalized once more. A rapid remission again occurred. After this, we succeeded in placing him in an environment in which he felt safe, where he made friends and could cope with simple work.

It was originally supposed that Alzheimer's disease was present, but the later relatively benign course seems to denote that this was a case of famine atrophy. This appeared in a number of concentration camp prisoners, and is described in detail by Thygeson et al. (10).

The two other patients—one had a chronic brain syndrome associated with senile brain disease and the other a chronic brain syndrome associated with central nervous system syphilis—showed completely analogous pictures of illness.

In all these cases it was clear that the formation of the paranoid delusions was determined by the patients' psychological situation, but the organic process and its symptoms had a parallel course with constant interaction of the two causal chains.

Case 2 also shows that the integral strength of a patient can be influenced by an adequate adjustment of external conditions, even though a chronic brain syndrome may be present. This strongly supports Ehrentell's and Neustadt's observations, and these are further emphasized in Norway by Houge (5) among others and by the author in a previous paper (2).

The observations presented hitherto do not, however, give any answer to the question whether two separate causal chains may not also be assumed to be present in so-called "functional" psychoses. With regard to general paranoid reactions, we have not been able to find anything to support this assumption in the present investigation of all psychotic refugee patients. In all cases it was clear that situation-conditioned reactions precipitated and determined the psychotic development. The refugee existence with its insecurity was in most cases the decisive factor. This fact best explains why the observed incidence for the paranoid reactions is more than ten times higher than could be expected in a corresponding Norwegian population group—that is, 42 against 3.518. The course was benign, and, prognostically speaking, there was no difference between the refugee patients and a group of matched Norwegian psychotics of the same symptomatology.

The circumstances are quite different, however, with regard to the real schizophrenias. The author has been exacting in his demands to warrant this diagnosis, which in brief may be said to have to comply with the following criteria.

In a schizophrenic splitting phenomena with clear consciousness are considered characteristic, along with association disturbances, autism and primary delusions. To the splitting phenomena belong clear ideas and feelings of passivity (resulting, among other things, in "thought reading," "thought-stealing" and so on), derealization and depersonalization which are accepted by the patient without comment. For further details we refer to (4, 7, 8, and 9).

The observed incidence of schizophrenias is 14, compared to 3.964 that could be expected in a corresponding Norwegian population group.

All of the 14 schizophrenic refugee pa-

tients have paranoid symptoms. This in itself is not so remarkable inasmuch as the schizophrenias, apart from the classic hebephrenic forms, are often characterized by paranoid delusions. Our refugee patients, however, have persecutory delusions, which always introduce the actual picture of the disorder. The following example, which may be taken as a paradigm for all our 14 schizophrenic patients, shows this clearly:

The patient is a Polish, Roman Catholic, unmarried man, born in 1917. His parents are probably dead. He had not completed his schooling and had started to work on farms at an early age. He had come to Norway during the war and had spent it in a camp for forced laborers. After the liberation he chose to remain in Norway. He worked on different farms, was considered a steady and good worker and was regularly employed. He did not seek many contacts with other Polish ex-prisoners, was considered by them as rather an introvert.

Some time before hospitalization he received a letter from the International Refugee Organization (IRO) questioning him about his home town. He took this extremely seriously and became very anxious. He went to the police and complained that he was being persecuted, accused of spying and sabotage. The police referred him to a psychiatrist, but the patient refused to take any medicine, thought that it was poison and that the doctor was trying to get rid of him. In the mental hospital he showed further persecutory delusions, was hallucinated both visually and aurally, and had feelings of passivity and ideas of influence. He deteriorated in spite of ECT and insulin coma treatment. Later on, drug treatment was tried without any result.

The personally and politically insecure social situation of a refugee is, without

doubt, of the greatest importance in the development of the psychosis. A "relatively unimportant" happening, misinterpreted by the patient, is sufficient to start the psychotic process. This "relatively unimportant" happening has, however, touched on the patient's central problem—his feeling of insecurity—and the paranoid development is set going. It is, however, obvious from the course of the disease and from the case histories of all our schizophrenics that the persecutory delusions are only a pathoplastic feature in the picture of the mental disorder. In the course of the schizophrenic process these persecutory delusions become of less importance to the patient. He is not so preoccupied with them, even though they are still present, a fact which the author has been able to demonstrate in many patients by his follow-up investigations.

In summing up, we may say that we find the same persecutory delusions in patients with both paranoid reactions—with schizophrenias and with chronic brain syndromes. It should therefore be justifiable to assume that it is the same psychodynamic causal chain which brings about these symptoms. In the first group we mention the main causal condition appears to lie in the actual reaction between the individual's personality and the environment; other causal chains seem to be of far less importance. This assumption is supported by the extremely high incidence (42 observed cases against 3.5 expected) and the good later results.

In the latter—that is, in schizophrenias and chronic brain syndromes—there are other factors besides the psychodynamic causal chain which determine the development. In chronic brain syndromes the other causal chain at least is partly known. In the schizophrenias we have little knowledge of the other causal chain. However, the

present investigation appears to support strongly the assumption that it does exist and exercises its influence on the formation of the disease and final development. The typical schizophrenic symptoms in the depersonalization and derealization point very strongly in the direction of a pathophysiological component in the "specific schizophrenic causal chain."

The present investigation of psychotic refugees in Norway has been able to show common forces with psychodynamic effect due to the patients' lack of security and with a projection of their insecurity. Moreover, it has been able to indicate that even though this causal chain is common to all refugee patients and influences practically all pictures of the disease, the latter very considerably and their course is determined by the other causal chain, which is known in some cases but unknown in others, at least for the moment.

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Emotional reactions of patients and medical personnel to respiratory poliomyelitis

Although great strides have been taken in the direction of decreasing the incidence of or preventing poliomyelitis, new cases appear. Apart from this consideration, old cases remain. That the damage caused by the disease goes beyond physical disability and creates problems in the personal life of the patient, in his family and in hospital management has been the subject of reports in the literature (1, 2, 3, 4, 5, 6, 7). Those patients with bulbar poliomyelitis and respiratory paralysis who require confinement in a respirator or require artificial assistance with breathing are the most severely handicapped, require complete physical care and have more recently been the subjects of study from the point of view of their emotional reactions (8, 9). Prugh and Tagiuri (10) especially in a comprehensive review of the literature, in addition to an extensive study of their own with such

patients, have delineated in detail many of the problems that arise.

PATIENT REACTIONS

The material for this paper was obtained from a study of 6 patients who were confined to respirators and from a study of the medical personnel responsible for their care. Concern had arisen over the deteriorating morale of the patients, their increasing complaints about their care, their increasing demands, and the difficulties the personnel were having in dealing with them. Informal interviews with the patients did indeed establish the fact that they were complaining and demanding

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and, in addition, the fact that they felt helpless, depressed, anxious, dependent and hopeless and that they were expressing feelings and reacting to feelings, each in his own particular way. Further observations and interviews made it possible to delineate these reactions more specifically.

Thus, the patients understandably wished close and individual attention and became angry, uncooperative or anxious when it could not be provided to the extent desired. At the same time they sought approval from the medical personnel and were emotionally dependent upon them, although this was little recognized by the patients. Most particularly were the patients dependent upon the nurses; they sought approval from them and reacted with apprehension when the nursing personnel was changed. The patients were sensitive to all changes in personnel and routine so that food, time of eating, amount of food, position in the respirator, time of turning the television set on and off became matters of primary importance. They were also very much interested in the personal lives of those looking after them. Furthermore, they got to know a good deal about their nurses and doctors and physiotherapists, sometimes more than the various individuals would want anyone to know.

All in all, our findings in this area are in agreement with those of Prugh and Tagiuri (10), who in addition emphasize the denial, projection and primitive fantasy. Of these 6 patients with whom sexual matters were discussed, attempts at active suppression of sexual thoughts by the patients were revealed.

Much friction had arisen on the ward over the issue of time spent by the patients in and out of the respirator. As a group the patients were made anxious by the prospect of leaving the respirator and were

loathe to do so. With encouragement this could be accomplished, but then differences arose as to how much time out each patient could tolerate. Because of this background of tension, the views of the patients about the respirator were investigated.

The most striking and immediately available fact obtained was that each patient felt ambivalent toward the respirator. Being in the respirator represented all the tragedy of the disease—the immobility, the restriction of the environment and the active dislike of being in it. At the same time, however, the respirator came to be experienced as a part of the body, and anxiety was evoked by the prospect of being away from it even for a short period of time. Glud and Blane (9) have written about the body image changes in such patients and of the meanings to the patients of the various types of equipment used in their care.

In addition to the effects of the disease *per se* we must consider the impact of the disease upon the preexisting personality of the patient. The reaction of the patient was a composite of the physical and emotional effects upon him of the disease in the current situation and upon his prepoliomyelitis physical and emotional equipment. Accordingly, depression was more prominent in one patient, denial in another, demanding behavior and hostility toward medical personnel as authority figures in a third. In addition, all these patients were completely dependent upon others for their physical needs and were readily stirred to anxiety or moved to anger or petulant and demanding behavior. These patients required constant attention, were, in fact, physically dependent upon the respirator and very quickly became emotionally dependent upon it as well, and upon the medical personnel. The constancy of the care and attention that was

needed by them constituted a daily drain upon the emotional resources of those concerned with this care.

REACTIONS OF MEDICAL PERSONNEL

Robinson and Finesinger (11) have commented upon the issues facing medical personnel in dealing with patients with poliomyelitis. "To the attending physician who does not realize that his own appraisal of reality fits poorly with that of the patient's this is no problem: the physician will continue to be baffled by or will simply ignore the relationship difficulties which he does not understand. To the more insightful physician who realizes that his own judgment is but one of several perceptual wholes relating to the illness it is an issue which must be grappled with . . . other professionals . . . may acquire a greater measure of responsibility for the treatment of the patient . . . the physician may be aware that a part of his role is being usurped by others and with this feel threatened." The authors go on to point out that interprofessional tensions may then arise as a result of which the patient is likely to suffer.

We observed a variety of reactions in the medical personnel—physicians, nursing and attendant staff, physiotherapists were all affected in one way or another by respirator ward duty. Some staff people were consciously and at first acutely aware of anxiety in dealing with these patients. In others, guilt was mobilized, and still others tended to identify with the helplessness of the patient. A certain measure of firmness and encouragement was always required in acclimating the patient to some period of time daily outside the respirator. A similar attitude was usually required in helping the patient tolerate a certain amount of discomfort during physiotherapy. When the physician's anxiety

and guilt were high, his inclination was to be lax in the performance of these important therapeutic tasks, particularly when the patient objected to them.

Other of the medical personnel denied or were not aware of any anxiety. In consequence, they manifested certain characteristic behavior such as avoidance of or minimal contact with the patient. In the physician this took the form of perfunctory ward rounds or absence from them if this could be arranged. During rounds the physician focused his attention on the respirator or upon the chart and in some instances hardly looked at the patient. The patients were, of course, aware of this minimal personal attention and often played games during rounds in which they said they were hemorrhaging to death and then joked among each other about the fact that the staff had been so busy with rounds that the comment had not been heard.

This kind of avoidance by the physician had its effects on the rest of the staff in that discussions with the nurses revealed that they felt what they considered to be a lack of interest by the physician. The nurses indicated that they felt alone or abandoned by the physicians and that not enough interest was shown in the patients or in the problems the nurses had in ward management.

Still another variant in the staff's methods of defending against anxiety had to do with the denial of the effects and implications of the illness upon the patient. This often paralleled a similar mechanism of defense on the part of the patient. In practice, this type of staff defense meant that the physician or nurse expected complete recovery or steady improvement and became insistent, for instance, upon certain specified daily increments of time spent in the

respirator or expected the performance of tasks of which the patient was physically incapable. Since the performance was rarely if ever forthcoming, these people not infrequently found themselves becoming angry or impatient with their charges or pushing them beyond their tolerance.

A special word is in order concerning the nurses. To understand the role of the nurse in this setting, one must above all recognize that the nurse had a position in the front line of exposure to the intense (though often unrecognized) emotional forces mobilized in this setting. The nurse was exposed to the patient all day every day, to his relatives, to his reactions to his illness, to her, to the hospital and to the physician. The nurses reacted with the defenses appropriate to their individual personalities. Some nurses could not long withstand the anxiety and requested transfer. Others were prone to coerce patients into excessive activity. Still others became especially attached to one patient and overly permissive and attentive to him with the consequent tendency to avoid the others.

Some few members of the staff became overly rigid, authoritative and coercive in dealing with the patients. This applied not only to physical care but to visiting hours, recreational activities and setting hours for going to sleep. Such a physician or nurse found himself becoming increasingly angry with the patients and expressed his anger directly to the patient or indirectly by insisting that the patient was not staying out of the respirator long enough or was not cooperating sufficiently during physiotherapy. One such staff member insisted that the greatest danger in dealing with the respirator cases was to feel sympathy for them since if one did feel sympathy for them all was lost.

Our attention was directed also to the

obviously increasing tensions and disagreements among the staff. Some physicians were critical of the ways of other physicians, and some placed the blame for morale and ward management problems upon the nurses. In turn, the nurses felt they were being asked to do the job alone. The physiotherapists felt isolated too. The various physicians and nurses became reluctant to communicate with each other, or if they did communicate it was in terms of criticism, one of the other. Typical nurse complaints had to do with the physician's lack of interest in or knowledge of the patients.

PATIENT MANAGEMENT

Exploration and recognition of some of the sources of patient and personnel anxiety evolved into the need for some attempts at correction. Extensive psychotherapy with the patients seemed neither warranted nor feasible. The collecting of the data in itself afforded some opportunity for simple ventilation by the patients. It was further obvious that the correction of misunderstandings would have to be undertaken by the staff itself, and by way of guidance the data collected from observations of the patients were made available to the staff with some recommendations for ward management. Thus, neither overly permissive nor overly authoritative management was suggested. Some things which in the lives of those not confined to a respirator might seem trivial were very important under these circumstances; giving the patients a preference in choice of food, visiting hours, hours of television watching, though apparently mundane, was of considerable significance to them.

STAFF

In an attempt to clarify some of the issues

involved and to improve communication among the medical, nursing and physiotherapy staffs involved, regular staff meetings were agreed upon for the purpose of discussing the respirator patients. Our intention was to conduct these meetings in accordance with the principles of group therapy but with the focus on the patients and reactions to the patients rather than upon problems of the group itself or of any individual staff members.

During these meetings many of the attitudes and anxieties already referred to became manifest, although not necessarily recognized. The meetings did serve the purpose of ventilating some staff complaints and irritations; they did lead to a recognition of differences of opinion concerning personal views in patient care. However, no far-reaching changes in the feelings of any single individual took place insofar as could be determined. The meetings were discontinued when changes in staff personnel made continuity impossible.

Although a group program that extended over a longer period of time would be necessary in order to draw any definite conclusions as to its value, sufficient material did come out of this group to give the impression that such an opportunity for staff communication is valuable for staffs concerned with the care of respirator patients and of other patients with chronic physical diseases requiring prolonged hospitalization in the same institution.

SUMMARY

1. A study of the emotional reactions of six patients who were confined to respirators because of bulbar poliomyelitis and of the emotional reactions of the medical personnel responsible for their care is reported.

2. As a group the patients had feelings of anxiety, hopelessness, helplessness and depression. The anxiety was often manifested in dependent, demanding, angry or uncooperative behavior. To a varying degree the patients denied the implications of their illness.

3. The constancy of the care and attention that was needed by these patients constituted a daily drain upon the emotional resources of those concerned with this care. The medical personnel responded to the anxiety inherent in this situation in various ways. Some were aware of the anxiety; others denied it. Some experienced a sense of guilt; others displayed overprotective behavior. Some staff people tried to avoid the patients; others became coercive or excessively authoritative. Tension and misunderstanding arose among patients, nurses and physicians.

4. An attempt was made to help with the ward management problems that arose by assisting the staff in recognizing the patients' reactions as well as their own to the disease.

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GERTRUDE L. NILSSON

ALBERT A. KURLAND, M.D.

The general practicing physician as a resource for the mentally ill

As attempts are made to indoctrinate the public in seeking help with mental illness, it becomes of interest to sample from time to time the effectiveness of such efforts at public education. Recently an opportunity was provided to obtain some information relative to the present status of the general practicing physician as a resource for the mentally ill and their families. This information was obtained in a study of the prehospital medical histories of 100 patients admitted to the Spring Grove State Hospital in Maryland in 1958 (1).

The study was conducted by the hospital's department of medical research in connection with a project to compare the relative effectiveness of 6 phenothiazine medications in treating acutely disturbed patients newly admitted to a state psychiatric hospital. This project (MY-2152) was financed by a grant from the National Institute of Mental Health and administered by the Friends of Psychiatric Research, Inc. of Baltimore.

The findings provide a partial answer to one of the questions posed for further study by Charles F. Mitchell, director of the division of mental health of the Texas state health department, at the conclusion of an article in the October 1958 issue of *Mental Hygiene*: "To whom do families turn for guidance when they first recognize symptoms of severe mental illness in a family member?"

Although the comparative drug study was not concerned with guidance resources in general, it did reveal the medical treatment resources of the first 100 patients admitted to the project—men and women between the ages of 18 and 65 who were not alcoholics, who displayed no evidence of any acute or chronic brain damage and who were considered by the hospital psychiatrists to be good candidates for pheno-

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thiazine tranquilizers on the basis of such target symptoms as hyperactivity, hyperemotionalism, aggressiveness and the general appearance of acute disturbance.

In the group were 40 men and 60 women. Fifty had been admitted previously to psychiatric hospitals, and 50 were admitted for the first time. They came from an area in Maryland covering the full range of urban to rural environments, and from a wide variety of social and economic levels. More than 70% of the diagnoses were various types of the schizophrenic reactions; among the other diagnoses were personality disorders, anxiety reactions, manic-depressive psychoses, psychoneurotic depressions and drug addictions.

For 22 of these 100 patients the histories show that, whether or not they recognized the symptoms of mental illness, they made no effort to get medical treatment. All of these came to the hospital as a result of intervention by outside agents—in all but 3 cases, the police.

For an additional 17 (of whom 12 had previously been hospitalized), the state psychiatric hospital was the first medical resource to which the patients and/or their families turned; they applied to other community agencies only during the admissions procedure. One family took their patient directly to a private mental hospital. There is no way of determining the extent to which the hospital was considered by these 18 and their families as a medical resource, as distinguished from a place of confinement or retreat.

There were 60 patients with records of applying for extramural medical help. Of these 42 had turned first to physicians who were not specialists in psychiatry—39 to men in general practice, 2 to obstetricians and 1 to an internist. Seven others turned first to psychiatrists in private practice, 7

to general hospitals, and 4 to psychiatric clinics.

For 11 patients the nonpsychiatric physician was their only medical resource before admission to the hospital. For 30 more he was the principal source of whatever treatment they had received.

Only 30 of the 60 who had sought extramural medical treatment reported that they had done so as soon as symptoms of mental illness appeared. The other 30 acknowledged in retrospect that they had delayed in seeking treatment, some for only two weeks, many for more than a year, and one for nearly nine years.

Further analysis of the data accumulated in this study is in process to determine the kinds of medical treatment these acutely disturbed patients received before they entered the state psychiatric hospital, and, if possible, what factors are responsible for the failure of so many of them to get medical treatment which might be considered adequate. Professional authorities and the lay leadership of the Mental Health Associations are currently engaged in a variety of efforts to reduce the traumatic effect of mental illness on the patient, his family and his community. The findings in this study and in other studies of the prehospital and posthospital experience of the mental patient may well serve to indicate what kinds of educational programs and what kinds of community services may best serve this purpose.

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DOROTHY DURLING

State hospitals make a new start in vocational rehabilitation

According to Linder and Landy¹ research in the vocational rehabilitation of psychiatric patients has been of a "limited and pioneering nature." This is particularly true of state hospital patients, about whose vocational rehabilitation even less has been reported than about other psychiatric patient groups, such as patients discharged from Veterans' Hospitals, psychiatric clinic patients, etc.

There are a few outstanding exceptions. In 1947 the division of rehabilitation of the National Committee of Mental Hygiene authorized a survey of the vocational rehabilitation services in the state hospitals of New York, Connecticut and Michigan. The findings were published in an enlightening summary by Rennie and others.² The authors expressed the opinion that many individuals could successfully work even during periods of emotional or mental stress, and even that some persons who

were actively psychotic could still be effective workers in the community. The vital need for vocational rehabilitation for certain patients was underlined by the authors, who believed that the self-confidence of some patients "had been so badly shattered" that they could not think constructively about their own rehabilitation until their self-confidence had been at least partially restored.

The Barden-LaFollette Act of 1943 provided that vocational rehabilitation may

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¹ Linder, M. P. and D. Landy, "Post-discharge Experience and Vocational Rehabilitation Needs of Psychiatric Patients," *Mental Hygiene*, 42 (January 1958), 29.

² Rennie, T., T. Burling, and L. Woodward, *The Vocational Rehabilitation of Psychiatric Patients*. New York, Commonwealth Fund, 1950.

TABLE 1

Three years of vocational placement

REGION	NUMBER OF OF HOSPITALS REPORTING	NUMBER OF PATIENTS PLACED BY HOSPITAL	NUMBER OF PATIENTS PLACED BY STATE AND FEDERAL GOVERNMENT	TOTAL PATIENTS PLACED
1	12	161	38	199
2	16	110	179	289
3	43	443	890	1333
4	17	53	168	221
5	25	131	514	645
6	1	1425	000	1425
Total	114	2323	1789	4112

be given to those mental patients who need and can profit by these services. Rennie² estimated that 15% of those leaving the hospitals need and can profit by these services. In order to learn and report what the various state hospitals in the United States are now doing in the way of vocational rehabilitation, the writer sent a questionnaire to the 215 state hospitals listed by the National Institute of Mental Health, Bethesda, Md. The questionnaire solicited information about the number leaving the hospital in the last three years and the number who received vocational rehabilitation during this period. The questionnaire also inquired about planned vocational education in the hospital, about pay for patients, daywork and vocational testing. Comments were invited. A total of 114 replies were received (53%).

A few of those listed proved to be hospitals for sex offenders, for geriatric cases, for psychiatric patients who were also tuberculous, and for the criminally insane. Most of these were doing little or nothing

in the way of vocational rehabilitation. However, there was one notable exception. The psychiatric division of a middlewestern penitentiary replied that during the last three years jobs had been found for 500 individuals leaving the institution and that courses in vocational orientation, commercial and various kinds of trade training had been provided. Planned vocational training was given to 400, or 63% of the population. The respondent remarked: "All inmates of the psychiatric division with the exception of senile and hospital patients are either in academic or vocational schools or are receiving training on the job under the supervision of vocational instructors."

VOCATIONAL PLACEMENT

Three years of vocational placement services are tabulated in Table 1. For convenience, the states were divided into regions: 1) New England, 2) North Atlantic, 3) middlewestern, 4) far western, 5) southern and 6 territories.

Forty-seven hospitals replied to two questions: "How many patients left your hos-

² Rennie, *op. cit.*

pital in the past three years by parole, discharge, extended visit, etc.?" and "How many patients received vocational placement during this period?" The one territorial hospital which responded to both questions had placed 83% (1,425 patients). However, most of the 47 hospitals answering both questions placed only 1% to 2% of those who left. Although this is far below the 15% postulated by Rennie as needing and being able to profit by vocational services, it is nevertheless a beginning in the right direction.

NEW PROGRAMS

Eighteen hospitals noted that new programs of vocational rehabilitation had been established recently. A Pennsylvania hospital replied that planned experiences for typists had been in operation for the last three months. With the help of volunteers, selected patients have been sent out to work during the day for social work agencies in the community. A hospital in Michigan has recently set up a sheltered workshop in which patients sew or knit one day a week for pay. A new rehabilitation unit has been established recently at a state hospital in the south. It provides diagnosis, guidance and physical restoration. The

personnel for this unit includes a full-time secretary, a part-time rehabilitation worker, a psychologist and an occupational therapy worker.

Twenty-two hospitals reported that vocational counselors from the state bureaus of rehabilitation had been assigned to them recently. Three of these counselors work full-time at the hospital and the rest work one to three days a week.

PLANNED VOCATIONAL EDUCATION

The number of hospitals providing at least some planned vocational education is shown in Table 2.

Thus, 50 hospitals (49%) provided at least some planned vocational education. Forty-four of these indicated the number of patients receiving such education at the present time. The largest numbers reported were 475 patients at one of the territorial hospitals and 400 at a middle-western hospital. The median number was 15.

The types of training provided and the number of times reported are indicated in Table 3.

The following were listed once: librarian, hydrotherapist, chef, laundry, nurse's aide, shop mathematics, home nursing.

TABLE 2

Number of hospitals providing planned vocational education

REGION	NUMBER OF HOSPITALS REPLYING TO QUESTION	NUMBER OF HOSPITALS WITH PLANNED VOCATIONAL EDUCATION	PER CENT
1	11	7	64
2	17	6	35
3	36	18	50
4	14	9	64
5	24	10	42
	—	—	—
Total	102	50	49

TABLE 3

Types and frequency of vocational training

TYPE OF TRAINING	NUMBER OF HOSPITALS REPORTING FOR THIS SERVICE
Vocational orientation	26
Commercial	23
Trade	19
Domestic science	17
Farming	10
Animal husbandry	7
Dairy	8
Beautician (beauty parlor)	2

Some hospitals had several different types of trade training. The following were listed: book-binding, printing, woodwork, photography, ceramics, weaving, carpentry, porter work, upholstering, blueprint reading, power machine sewing, plant maintenance, baking, tailoring, poultry raising, shoe repair, plumbing and mechanics.

In Massachusetts a newly organized Commission on Rehabilitation, after surveys of job openings in the community, noted that in spite of the then-current business recession stenographers and typists were at present in demand.⁴ A training program for typists, accommodating 25 at a time, was established at a state hospital near one of the large cities.

According to the rehabilitation law, the division may provide a vocational instructor if the hospital provides space and equip-

⁴ Commissioner Francis Harding in an address to the Massachusetts Association for Retarded Children, at the Wrentham State School in May 1958.

⁵ Rennie, *op. cit.*, 74.

⁶ Pfeffer, Peter. "Money—A Rehabilitation Incentive for Mental Patients," *American Journal of Psychiatry*, 110(August 1953).

ment and makes a start on the training program.⁵ In accordance with this provision, a state hospital in New Hampshire offers a series of business courses. They are taught by instructors from a neighboring business college. The hospital provides space, facilities and supplies while the State Division of Rehabilitation pays for the instructor.

Commercial courses are provided also by hospitals in Iowa, Nevada and California. Two years ago a hospital in Louisiana set up a mechanics trade school on the grounds of the hospital. A hospital in New York is now providing training for four selected patients in cooperation with the State Division of Rehabilitation. One is being trained in photography, another in business, a third as a nursery school teacher, and a fourth as an x-ray technician.

PAY FOR WORK AT THE HOSPITAL

Paying patients for their work is a controversial matter. It may be argued that the value of the work seldom or ever equals the cost of the patient's care. However, it seems possible that paying small sums to patients who are almost ready for parole would result in saving money for the state. In the various hospitals of New England men and women are now being employed to do work which patients might do for limited periods, such as porter work, housework, sewing, etc.

It is a question, also, whether the rehabilitation value of even small sums might not be great enough to more than pay for itself. Such pay might mean a restoration of a lost self-respect and sense of independence which are basic to any rehabilitation program. A system of pay for mental patients has been established in certain veterans' hospitals with notable success.⁶

Thirty-two (28%) of the hospitals stated that at least some patients were paid for

their services. About two-thirds of these made small token payments of 40¢ to \$3.25 a week, sufficient to pay for small canteen supplies. The hospital with the largest percentage on the payroll was one of the territorial hospitals. This hospital pays 475 patients (39% of its population) \$2 a week. A southern hospital has 1,100 patients (22%) on the payroll; it also pays \$2 a week. Another southern hospital pays 50¢ a week to 14% of its population and a North Atlantic hospital pays 40¢ a week to 13%.

The institutions with the larger amounts of pay have only a few on the payroll. For example, a far western hospital which pays \$15 a week has only six patients on the payroll. Likewise, a Massachusetts hospital paying \$16 a week has only five patients on the payroll. The last annual report of this hospital states: "During the year we will continue to experiment with the new program of patient employment. Carefully selected patients will be put on the hospital payroll."

PAID DAY WORK

Outside day work may be regarded as a valuable device for bringing state hospital patients into contact with the community and as a feature of the new trend for lowering the barriers between inmate and citizen. Forty-three (38%) of the hospitals reported that at least some patients were now doing day work. A hospital in California has 100 patients on a day work schedule, and a hospital in Michigan permits such employment for 86 to 110 patients. These were the largest numbers reported. Two-thirds of the hospitals had fewer than 20 on a day work schedule, and a few noted that day work was allowed only in the summer.

The largest amount of pay was \$14 a day; this was paid to 20 patients in a Texas

hospital. Daily pay varied from 50¢ to \$14, with a median at \$4.75.

SHELTERED WORKSHOPS

Seventeen (15%) of the hospitals stated that sheltered workshops were available for selected parolees from their hospitals. About one-third of these were affiliated with the Goodwill Industries of neighboring cities. The types of work mentioned most frequently were light assembly work, woodwork, office work and hospital work. Pay varied from maintenance only to \$27 a week.

VOCATIONAL TESTING

Sixty-one (53%) of the hospital said they gave vocational tests to patients, and several additional reported that patients were transported to the nearest state employment office for testing. The most frequently used test of intelligence was the Wechsler Adult Intelligence Scale, and of personality the Rorschach. The only vocational interest tests listed were the Strong Vocational Interest Test and the Kuder Preference. For vocational fitness, the General Aptitude Test Battery was mentioned three times.⁷

SUMMARY

Results of a survey of vocational services to state hospital patients in the United States have been reported. One hundred and fourteen replies (53%) were received.

During the last three years 4,112 recovered patients received aid in finding jobs. Typically, 1% to 2% of those leaving the hospitals received this service.

⁷ This is a relatively new test of high range and validity and is available only at the state employment offices. See Donald Super, "The Multifactor Tests," *Personnel and Guidance Journal*, 36 (September 1957).

About half of the hospitals responding provided at least some vocational education. A few were providing such education for 400 to 500 patients. The median number was 15. The most frequently mentioned type of training was vocational orientation, next commercial, then trade.

Thirty-two (28%) of the hospitals stated that at least some patients were paid for their services. Typically, only small numbers are on the payroll, receiving 40¢ to \$3.25 a week. However, a few have 400 to 1,100 patients on the payroll. A few pay \$15 to \$16 to small numbers of patients.

Forty-three (38%) of the hospitals reported that certain patients were now doing day work. Typically, the daily wage was \$4.75, with less than 10 on the payroll.

However, a few permitted day work for 80 to 110 patients.

Seventeen (15%) of the hospitals stated that sheltered workshops were associated with their hospitals, and 61 (53%) provided vocational testing.

About one-fifth of the hospitals noted that new rehabilitation services have been established recently with special state rehabilitation counselors working one to five days a week at the hospital.

Although the numbers of patients have been relatively small, about half of the hospitals responding were currently providing at least some vocational rehabilitation services. About one-fifth recently embarked upon new programs of vocational rehabilitation.

RONALD R. KOEGLER, M.D.

Chronic illness and the adolescent

The psychological effects of chronic illness can be devastating, and even relatively stable families are upset by such an occurrence to a family member. Realistic as well as emotional hardships result, with many individuals beside the patient affected. A great deal of time and effort of social agencies is regularly devoted to working with this problem.

Recent upheavals in our culture have further complicated the situation by bringing about complex changes in the family pattern. The decreased status of the father as head of the family, and a change in the recreational pattern with activities focused outside the home, are but two examples of influences which have lessened the ability of the family to provide support for its members.

A striking symptom of these changes is the dating pattern among adolescents, which is vastly different today from what it was twenty years ago. When comment-

ing on "going steady" among adolescents, President Charles W. Cole of Amherst states: "... The new ways may also be related to the search for security. The boy or girl who has a steady is secure. Each partner knows that the other can be counted on for the coming high school dance or the next football game. In a day when the population moves from home to home with such freedom and when so many homes are broken by divorce or otherwise, this kind of security is very precious to young people. Perhaps, too, general decline of competition under the welfare state has led to less competitive social customs. Just as the retail stores have tried to shelter themselves from all price competition behind the so-called fair trade

Dr. Koegler, a research psychiatrist at UCLA Medical Center, presented this paper, in part, at the 4th annual social welfare institute held August 8, 1957 in San Diego.

laws, so our young people have divided into noncompeting twosomes."¹

As President Cole suggests, behind these changes in the adolescent are changes in the family as a whole; the relationship between the members is much less strong and intense than it was thirty or forty years ago. Nowhere is the breakup of the family pattern more apparent than in its effect on the emotional security of the adolescent. "Going steady" and early marriage are a reflection of this basic feeling of insecurity, an effort to find in outsiders what they could not obtain in their own families.

This changing cultural pattern makes it more difficult for today's adolescent to adjust in a "healthy" way to illness. With the breakup of the family he feels less secure and has a greater need to belong, to have someone to lean on. Faced with illness, he has a greater tendency to become dependent and crippled by the illness, or else to deny any dependent feelings and refuse to accept the realities of his disease. Those working with these patients face an increasingly difficult task as more and more adolescents are seen who resemble this picture.

This is in addition to the "normal" confusion and restlessness of adolescence. Because of the very nature of adolescence, with the beginning of many adult feelings and responsibilities, a certain sense of anxiety and insecurity is almost usual. It is this insecurity which leads the adolescents to attempt to gain reassurance from their own age group, for example, or from those slightly older. They may despise those

younger than themselves but they are afraid of those very much older than they are, and consequently seek reassurance and security among themselves. They may not like what the group or gang demands of them, but will go along with this in order to show that they can do what others do and that they deserve to be "accepted."

It is very easy to observe this in the sexual sphere. Adolescents are normally worried about their sexual role, and a reflection of this concern is seen by again using the dating pattern as an example. In the words of Lawrence Frank: "Dating appears to be a highly stylized form of interaction between teen-age boys and girls, in which they act and speak to each other primarily in terms of how their behavior will be rated by their own age group. Thus dating involves prestige, status, skill in a 'line,' approaches to intimacy and sexual provocation, but no consummation if the boy or girl is to maintain his or her standing. It produces constant anxiety and tension, frustration of any genuine emotion, and denial of spontaneous feelings and generosities. It persists as a self-created form of initiation ceremony (like that inflicted on adolescents in many cultures to test their readiness for and to signalize their entrance into adulthood). Dating is often highly disturbing and frustrating, even to the successful daters, and a source of endless unhappiness and acute anxiety to those who are not successful. It provides an occasion for release of sadistic impulses and for expression of masochistic needs, but it also often warps and destroys sexual functioning and needs."²

Traditionally the family was a means of support during this troubled period of adolescence. As the family crumbles in the Atomic Age, however, the normally anxious adolescent feels his sources of security—his parents—slipping from him. It

¹ Cole, C. W., "American Youth Goes Monogamous," *Harper's* (March 1957), 29-33.

² Frank, L. K., "This Is the Adolescent," *Understanding the Child*, 18(June 1949), 65-69. (Available also as a reprint from the National Association for Mental Health.)

is easy to see why the current practice of "going steady" has evolved as a stopgap attempt to bring some security into their lives.

The adolescent has always been a difficult person to deal with when chronic illness strikes. An important reason for this difficulty is that the need for group approval, so characteristic of the adolescent, places a premium on being able to do whatever the other members of the group do, and those limited by illness are made acutely aware of their handicap. In effect, they are "different," and there is nothing more disturbing to the adolescent than to seem unlike the rest of the group—to be outside the group rather than inside. At the time in his life when he is most insecure he is unable to use the strongest defense against insecurity that the adolescent has—group approval.

It is extremely common for children to accept handicaps fairly well until the onset of adolescence, and only then show signs of emotional disturbance. Anxiety about the way their own body compares to others is a normal phenomenon in adolescence, and serves to bring into prominence any physical defects. Desperate attempts to erect defenses against this anxiety often result in neurotic decisions and actions. This is illustrated by the following case.

Johnny M was a 16-year-old Catholic boy who had a congenital heart defect (interventricular septal defect). This had not prevented him from being very active and his parents attempted to see that he had a "normal" life. He participated energetically in sports and was fairly expert in basketball and football. He tired more easily than his peers but responded to this by continuing to exert himself even though feeling greatly out of breath. In his own mind he denied that there was anything wrong with him, although he had been

told by his parents that he did have some heart difficulty.

It wasn't until he was 13 and entering high school that trouble began. He went out for the football team and was turned down by the examining doctor on the basis of a "bad heart." It was after this that he became upset for the first time and seemed considerably depressed. He expressed a feeling that he would never get better and that it was useless for him to think about doing anything important later in his life.

Soon he began showing an interest in the priesthood and was encouraged in this by his parents. It was shortly after he had decided rather firmly that he would become a priest that he came to the UCLA Medical Center for an evaluation of his heart difficulty. It was felt that he would be an excellent candidate for surgery and when he was 14 a corrective surgical procedure was done, with the surgical expectation that his heart would then be perfectly normal.

Johnny had been rather pessimistic about the surgery and felt confirmed in this feeling when he did not feel much different afterwards. He went ahead with plans to enter a seminary as soon as possible in spite of some discouragement by his high school teachers, who felt that he was not ready scholastically.

Over the next two years he began to realize that his heart condition actually had improved and he was able to fully exert himself for the first time in his life. However, plans for the priesthood had gone ahead and at 16 he entered a seminary about 90 miles from home. From the first he had scholastic difficulties. Worried, he would go from one priest to another, asking about his grades and bothering them about how he was doing. The combina-

tion of the low grades and this anxiety reaction made them decide that he was not suitable for the seminary and he was transferred back to his high school.

Johnny accepted this dismissal fairly well and did not seem discouraged at all. He then announced that after he finished high school he would become a brother, one who, lacking the education of other members in the religious order, would do the menial work around the seminary.

When interviewed at this time he showed no anxiety, saying that his leaving the seminary was God's will. By thinking this way and applying it to other events which occurred to him, he was able to dismiss from his mind doubts and feelings of responsibility for his action. Psychological examination revealed gross feelings of inadequacy, both physical and emotional. Apparently he still viewed himself as a crippled individual, even though the operation had been successful and he appeared to be a healthy boy.

The family constellation gave some clues to his behavior. The father was of Irish extraction and remained distant from his children, similar to many other Irish fathers in the author's experience. Perhaps "unable to communicate" would be a better description of the father's problem with his children, but the result was that understanding between the boy and his father was minimal. The mother was of German stock and seemed to have a genuine interest in Johnny but little intuitive understanding of him. The family relationship was amicable but not close. All of his activities were centered outside the home—sports, school, entertainment.

DISCUSSION

Thus the situation became acute when Johnny entered his teens and could no longer avoid facing his physical defect. It was apparently not possible to secure strength through identification with a weak, nonunderstanding father, and so he sought a stronger father-figure in the church. This was a neurotic decision, and he was not prepared intellectually or emotionally for the seminary life.

Realistically he is sound of body, but unconsciously he still regards himself as inadequate. One can anticipate emotional difficulties in the future for this boy.

Johnny illustrates the lifelong psychological problem frequently brought on by chronic illness. It occurred even though the physical disability was effectively removed. Perhaps this indicates that such corrective operations should be done before adolescence, if possible, in order to avoid permanent distortion of the body image. Present-day families are frequently unable to fill their traditional role and provide support for the sick child.

SUMMARY

Emotional reactions to chronic illness frequently become manifest or accentuated with the onset of adolescence, related to the normal adolescent preoccupation with the body image. Recent changes in the cultural family pattern, with weaker family ties and supports, have accentuated this problem and must be taken into account in casework and psychotherapy. It is also suggested that corrective surgical procedures be performed before adolescence when this is feasible.

DANIEL I. MALAMUD, Ph.D.

Educating adults in self-understanding

In recent years we have witnessed a rapidly growing interest in the promotion of mental health in the population at large, and as this movement gains momentum we may expect that increasing attention will be paid to the challenge of devising methods for furthering self-understanding in groups of relatively normal persons (2, 3, 7). For the last 12 years I have been deeply involved with this very problem at New York University's division of general education where I teach noncredit courses in self-understanding for adults. The first course is entitled Workshop in Self-Understanding. Two additional workshops are provided for students who wish to continue on an advanced level. My teaching methods have evolved in the course of classroom experiences with groups of adolescent army recruits (1), nursing and medical students, labor union members and executive secretaries (8). In the present

paper I shall summarize my workshop approach at New York University, centering mainly on those planned procedures which I have found most useful in the first course.

A workshop meets once a week for 15 weeks; each session lasts an hour and three quarters. While the first workshop is open to any adult who wishes to register for it, a previous course in psychology is a prerequisite for the advanced workshop, and the workshop in self-exploration (the most advanced of the three courses) requires my permission for admission. The adults who attend these courses vary widely in age, education and socioeconomic background, with both sexes well represented.

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Over 60 students usually register for the first workshop, and about 20 to 30 for each of the advanced workshops. (I was flabbergasted at first at the prospect of working with such large groups, but I have come to learn that the size of a class does not bear any necessary one-to-one relationship to its cohesiveness, emotional involvement or rate of progress; much depends on what the group does together, on my relationship to the group and on the kind of atmosphere we can establish together.)

The majority of the students appear to be relatively normal men and women who function adequately—even with considerable self-satisfaction—in many life areas, yet who desire help in understanding themselves. Puzzled by contradictions in some of their feelings and actions, many of them seem to be groping for a sharper definition of their identity and an extended awareness of why and how they have become the kinds of persons they are. Some, on the other hand, appear to be motivated more by the hope that they will acquire “prescriptions” for personal problems or techniques for influencing others than by an interest in achieving a deeper self-awareness. More detailed definitions of the different motivational patterns with which students come to class, the relative frequencies of these patterns and how they relate to outcome will need to be determined by future research.

GENERAL APPROACH

My central aim in the first workshop is to sharpen the student's awareness of one basic fact—namely, that unconscious, inner forces play a part in governing his everyday behavior. The student's spontaneous experiences in the classroom can be most convincing illustrations of this fact, provided that he learns how to attend to these

experiences, becomes sensitized to noting their repetitive patterns, and gains skill in exploring their underlying significance. I try to “arrange” such learning experiences by introducing planned group procedures of a provocative nature which engage the student's personal involvement in exploring the meaning of his reactions. I am also quick to capitalize on unforeseen classroom occurrences which show promise of stimulating useful discussion—for example, an angry dispute between two students.

Instead of serving as an authority who gives the “answers,” I encourage members to act as participant-observers, to become attentive to the interplay of events in the classroom, and to observe themselves as they participate in these events. I aim especially at sensitizing the student to his feelings; while these provide vital clues to understanding his unique needs and wishes, he is often either unaware of just what he is feeling or unable to differentiate clearly one feeling from another.

When questions are directed to me in the early sessions I usually turn them back to the group. I do not hesitate to leave a question up in the air and move on to the next nor do I make any effort to leave the class with a neat summary at the end of a session. As the group begins to take more active responsibility for exploring issues that arise in class I gradually assume a more active role in the give and take of discussion. I underscore insightful comments, offer my opinions and observations, and correct serious misstatements of fact.

I encourage frank and open communication in the group by setting an example of such communication myself, by sharing with the group both my past experiences and my on-the-spot reactions. For example, when I invite the group to explore its first childhood memories I start the ball rolling

by submitting my own first childhood memory to the group for analysis. When I am anxious, pleased or irritated I try to share these feelings with the members if it seems useful to do so. I also set an example for the rest of the group in my curiosity about the commonplace, cautiousness about jumping to conclusions, and readiness to admit mistakes.

In order to progress in the workshop, members need to think out answers to their own questions, share thoughts and feelings which they ordinarily keep to themselves, and examine critically their habitual ways of thinking and feeling. It is not surprising that students experience some form of resistance in regard to fulfilling one or another of these requirements, but when such resistances are focused on directly and when the factors which underlie them are recognized and explored, what gradually develops is a most meaningful kind of learning. Examples of methods for helping a class to work through its resistances have been described elsewhere (5) and will therefore be given little attention here.

I request each student to mail to me after every session a one-page letter in which he reports his reactions to what transpired. I write out comments and questions in the margins of these letters and then return them to the group at the beginning of the following week's session. Each week the members mail in both the previous week's annotated letters and their new letters. In my written annotations I suggest new lines of exploration, give reassurance and encouragement when necessary, and correct any misunderstandings. These letters provide the individualized attention for which most students feel a strong need, help me to keep in close touch with new developments in both the group and in individual members, and enable me to deal

with anxieties and misconceptions very soon after they occur. Letters also provide invaluable data for studying the dynamics of the workshop process.

Probably all students experience some anxiety during the course. This is only natural and to be expected. In mild degree, anxiety serves as a constructive force in the learning process, shaking student's complacency about what has hitherto been taken for granted and spurring them on in their search for greater clarity about themselves. An excessive degree of anxiety rarely seems to develop. Students have at their unconscious command a variety of automatic mechanisms for warding off the impact of events that they are not ready to assimilate. In addition, the following safeguards and opportunities for extending reassurance have become a built-in part of the workshop process:

- Students are forewarned about the confusion, frustration and resistance they are likely to experience in the course. They are also cautioned against jumping to premature conclusions about themselves. I give frequent recognition to members' strengths and positive qualities, and I encourage students to view their shortcomings as inevitable outcomes of their life experiences rather than simply as faults to feel guilty about. I make free use of humor, especially in situations that threaten to become too "heavy."

- The introduction of films and other stimulus situations is carefully timed to fit the apparent readiness of the group. The student's right not to learn is respected, and I try to avoid pressuring anyone to move at a faster pace than he seems ready for. I emphasize that no one is required to speak in class and that many students learn as much by listening

thoughtfully as others do by taking an active part in discussion.

- In the course of exploring classroom events, students often report relevant personal experiences, and such reports are welcomed, but I discourage any extended discussion of an individual's current personal problems by pointing out the obvious limitations of the classroom situation for dealing with them. We center on the difficulties the group shares in the here-and-now classroom situation rather than on those that individual students have outside of class.

- I set aside the last ten minutes of each session for the airing of any hitherto unexpressed feelings and thoughts, and during this period I take the opportunity to give reassurance when necessary or to correct serious misconceptions. I also make myself available for a few minutes before and after each class period for any student who may wish to discuss his reactions to a session with me privately.

PLANNED GROUP PROCEDURES

I have developed a large repertoire of group "experiments" and other planned procedures designed to excite the members' curiosity about aspects of their behavior which they have hitherto taken for granted or considered insignificant. These methods involve the group in simple here-and-now experiences which are accessible to conscious exploration, elicit sharp individual differences in response and provoke students to search out for themselves the significance of these differences. Most planned procedures are designed to illuminate one or another of the following interrelated areas; individual differences, interpersonal relations and the role of childhood experiences in personality development. Examples of procedures in each of these areas

will be summarized below. It will be obvious to the reader that these procedures are not finished products which can be applied in a mechanical fashion. The basic elements of each method often need to be varied appropriately in different group situations, but these variations will not be considered here.

INDIVIDUAL DIFFERENCES

Throughout the course I focus attention on how differently members react to the same situation and how these differences may reflect their varying orientations towards life. Confronted by reactions strikingly different from their own, many students cannot help but wonder whether their responses are as inevitable and as objective as they had assumed. They begin to examine their perceptions and judgments more critically, and gradually become aware of the many subjective factors which may enter into their reactions.

Mental health films which dramatize life stories are very useful for bringing out individual differences. Instead of postponing discussion until after a film is over, I stop the film at appropriate points and discuss scenes on the spot, asking members how they feel about each character, encouraging them to predict how characters will behave in later scenes, and inquiring as to what events in the movie scene remind them of what goes on in the workshop. In response to these queries, dramatic individual differences usually make their appearance and are examined in discussion.

Confronting the group with a crisis-in-miniature also elicits sharp individual differences. For example, at my request, three women students role-play in turn the part of a mother who tries to get her five-year-old son to stop his play and come in to dinner. With each of the volunteer mothers separately, I play the part of the

son, who after a minute or two of irritable resistance to his mother's pressure bursts out, to each "mother's" real surprise, "Oh, why don't you drop dead, you old witch, and never bother me anymore!" Most members split sharply in their reactions to this outburst, some identifying with the child, some with the "mother"; some believe that the child really meant "drop dead," while others are strongly convinced that no five-year-old could really mean "such a terrible thing."

Several procedures have a playful, game-like quality and yet can be effective in stimulating sober self-questioning. In one session, upon request, each member brings in a balloon. I inquire how they went about obtaining their balloons. Some report they themselves bought the balloons. Others asked friends to buy the balloon for them. Still others come to class without any balloon, confident that another student will have an extra one, and indeed some students do bring extra balloons! After discussing the possible implications of these individual differences, I suggest that they blow up their balloons and then report what inner experiences they had as they engaged in this task. A number of students feel "exhilarated"; others feel "silly and embarrassed." Some fear they will be inadequate to the task, while others fear they will "go too far" and break the balloon! Following the group's analysis of these differences I request the members to rub their blown-up balloons gently against their faces, keeping their eyes closed as they do so, and to "permit" some image to pop into mind. The reported images range from those which are frankly sensual and involve human beings to those which are abstract and impersonal. The possible factors underlying these differences are explored. My final instruction to the

group is to break the balloons. As one would expect, members break their balloons in quite different ways and vary markedly in their degree of inhibition about engaging in this destructive act.

I strive to sensitize students to differences in the nonverbal aspects of their behavior and how these too express their varying styles of life. For example, I direct attention to their choice of seats in the classroom, and I question whether their consistent choice of certain seats might reflect general life attitudes. After some discussion of this, I ask all members to change their seats, to find a seating position as different as possible from their usual one, and to observe their own and each other's behavior as they go about this task.

Individual differences in response to the workshop experience itself are explored in many ways, one of the most fruitful being through the medium of dreams: I ask all members to dream about the workshop on a given night and to bring their dreams in for group analysis. Details of the procedure that I follow in the session devoted to dreams and examples of such workshop dreams have been reported elsewhere (5).

INTERPERSONAL RELATIONS

Through an examination of their relationships to each other and to me, students can learn about the un verbalized assumptions they make about others and the interpersonal techniques they employ habitually to meet emotional needs and avoid anxiety. Competitiveness, fearful withdrawal, aloof superiority and efforts at gaining approval are among the common relationship patterns exhibited in the classroom, providing many rich opportunities for learning how one's actions affect others and vice versa. Exploration in this area, however, proceeds very gently and gradually, and is

more heavily emphasized in the advanced workshops.

I have found the following series of tasks useful both as a rapid means of acquainting members with each other (especially in helping them to identify each other by name) and as an intriguing introduction to interpersonal dynamics: I ask each person in the group to give in turn his first name and to tell us about a "favorite something" from childhood—a person, a book, an activity, or whatever. After discussing what they noticed about themselves and each other as they went about this task, I ask the members to write down as many of the first names in the group as they can recall. Students vary markedly in the number of names recalled, and we discuss what factors, other than sheer memory capacity, might account for this range of differences. When I inquire how they went about trying to recall names, some individuals report that they proceeded systematically by writing down the name of the first student in the first row, then the second student's name, and so on, while others state that they wrote names down as they popped spontaneously into mind. We explore what different personality factors these contrasting approaches might reflect.

I then ask those persons who recalled names spontaneously to read off the first three names that came to mind, and to consider whether these names may have had some special significance for them. After looking into this possibility with the group I ask each member to close his eyes and repeat his name to himself, noticing what thoughts, feelings or images occur. Many students are startled at the negative or positive associations which come to them; these are reported and discussed. Finally I instruct members to call for those

names they still cannot recall. After this instruction has been followed I wonder out loud why students found this or that person's name difficult to recall, and we explore what personal reactions to particular members or what emotional reactions to their names may have led to the memory blocks.

I often ask the group to report its observations of me. At first students are quite inhibited about making such reports, and after I point this out we go into the fears which block them. Gradually gaining courage, they begin to express what they notice about me, almost invariably touching off some productive discussion. (One student, for example, observes that I smoke a lot and wonders why. The class bursts out laughing, and I join in the laughter. I tell the student that smoking relieves the tension I experience in standing up before a group. I then suggest that the group's laughter reflected sudden anxiety, and we explore what might have prompted this development, before long discussing their "need to put authorities on pedestals, and also to knock them off.")

I present "Facing Reality," a film deliberately chosen for its superficial quality. When I ask the group for its reactions to the film, various favorable comments are made about it. I then tell the members that I think the film "stinks," give my reasons, and inquire whether others had similar reactions. Some members now admit that they had similar critical thoughts. In the discussion which follows we explore why these students felt inhibited about expressing their reactions earlier, their fears of "criticizing a film chosen by the instructor," and their conflicting attitudes towards authority.

Various procedures are designed to confront the student with the impression he makes upon others as well as to encourage

him to explore what inner factors determine his varying emotional reactions to different members of the group. The following "experiment" was inspired by Kelly's "Role Construct Repertory Test" (4): I request three students who are interested in learning what impression the group has of them to volunteer to be subjects. I then ask the group to judge in what ways two of the three volunteers are alike and different from the third. A number of members then give their impressions, some noting a resemblance in one pair of the trio, others in another pair. At my suggestion their categories take the form of images whenever possible. (For example, "Bert and Lenny are like volcanoes that explode, whereas Irving is like a volcano that just rumbles underneath.") After the group has made its "sortings" of the trio, I ask the three volunteers to give their reactions to the group's categorizations. After repeating this procedure with several volunteer trios I ask the students to consider whether the categories they used in judging others may reflect aspects of themselves.

I often read to the class (without identifying the authors) carefully selected excerpts from students' letters; these excerpts may refer to critical class events or to significant expressions of feelings about me or others in the group. (The students are informed at the beginning of the course that such readings may occur.) After reading a series of such excerpts from different students I ask the class to give its reactions and comments. In the discussion which follows, students whose letters were read may preserve or discard their anonymity, as they wish. The timely introduction of students' letters in this way often enables a group to explore interpersonal undercurrents which might otherwise never be brought to the fore.

ROLE OF CHILDHOOD EXPERIENCES IN PERSONALITY DEVELOPMENT

In the course of discussing their individual differences and interpersonal relations I encourage students to speculate about the kinds of childhood experiences which may have predisposed them to react as they do. I also introduce various procedures specifically designed to focus the group's interest on the formative influences in childhood.

Films such as "Angry Boy," "Lonely Night" and "Overdependency" are excellent portrayals of the effects of childhood experiences upon personality development. The usefulness of these films is enhanced if, before they are presented, the class is involved in some dramatic way in a consideration of the central issues raised by the film. For example, prior to the showing of the film "Feeling of Rejection," dealing with the conflicts generated by Margaret's compulsive need to comply with the wishes of others, I ask the group to write out completions to the following sentences: "Mother liked me best when I . . ." "People like me best when I . . ." "I like myself best when I . . ." I collect the members' papers, read a number of them aloud, and discuss with the group the implications of each set of completions.

The Adlerian emphasis on the value of first childhood memories inspired the following procedure: I pass out paper to the group and ask each member to write out his very first memory. I then introduce the notion that first memories may reflect basic attitudes (both past and present) towards ourselves and others. I relate some sample first memories to the group, and we speculate freely about what these memories imply, with the understanding that our speculations are only possible hypotheses. When students show that they have caught on to some of the suggestive

clues contained in memories I ask them to examine their own recollections and to write interpretations of them on the other side of their sheets. I then collect the papers and choose one to read to the group without mentioning whose memory it is. After the group gives its reactions I turn the memory over to the other side and read the student's own interpretation. I then invite the individual whose memory it is to give his reactions to the group's speculations. This procedure is then repeated with the memories of as many other students as possible.

The following procedure has been useful in stimulating personalized discussions of the mother-child relationship: I request members to close their eyes and to hear their mothers' voices as they heard them in childhood. After a few moments I ask them to open their eyes and to report what they observed in themselves as they went about this task, what they heard the mother say, her tone of voice, and the surrounding situation. The members note how different these "heard" statements are and go on to explore what these differences might suggest about the meaning of the mother-child relationship for different participants.

The following procedure was suggested by Alfred Adler's emphasis on the significance of birth order: After presenting the film "Sibling Relations and Personality" I break up the group into subgroups according to birth order (oldest children in one group, youngest in another, middles in still another and "onlies" in a fourth group) and request the members of each subgroup to explore what kinds of experiences they had in common as a result of being the oldest, the youngest, etc., and how these experiences influenced their later development. Thirty minutes later I call the subgroups together to present their findings for general discussion. At

some appropriate point I ask the members if they can trace any relationships between their birth orders and their behavior in the workshop.

I devote one session to an analysis of members' photographs of themselves as children: I ask each student to bring in three photographs of himself as a child below the age of six, pictures in which he appears with parents or other persons. Each set of photographs is projected one at a time onto a large screen so that the group can study together the child's stance, facial expression, degree and kind of physical closeness with others in the photograph, and other physical clues. The group, usually unaware of the photographed subject's identity, gives its impressions of the child's personality, the problems he may have faced as a child, and how he might have attempted to cope with them. Finally, the individual whose photographs were presented gives his reactions to the group's speculations.

FUTURE PROSPECTS

A majority of students report in written evaluations at the end of the course that their eyes have been opened to the meaning of some of their own behavior, and to that of others close to them. They describe specific changes "for the better" in their self-attitudes and in their interpersonal relations. They claim to have become more self-questioning, more alert to manifestations of the unconscious, and more aware of the complexity of human behavior. At the end of almost every workshop one or two members report that they have developed incentive or sufficient courage to seek psychotherapy for themselves.

These reports of my students and my own classroom observations have been encouraging indeed, but such criteria are too limited to provide more than impression-

istic answers to such questions as the following: What is the scope, depth and permanence of changes which take place in students, and to what extent are these changes attributable to the workshop? How do these changes come about in different students, and why do some students experience little or no change? How can the dynamics of the workshop process best be described? What role do the following factors play in this process: group composition, the instructor's personality and approach, the content and sequence of planned procedures, and crucial events unique to each group? Obviously, the future development of the workshop will require detailed descriptions of the teaching-learning process, the testing of hypotheses in controlled experimental studies, and the creative exploration of new group procedures.

My experiences with the workshop to date suggest that it can make a significant contribution to mental health education for the adult community. There are multitudes of relatively normal persons with mild emotional problems who desire help in understanding themselves as a means of increasing their capacity to enjoy life. Where can they turn for the kind of self-enlightenment they require? Magazine articles, books and lectures are sometimes helpful, but more often than not they represent sterile intellectual experiences in which new terms and concepts are absorbed in an abstract way without the kind of personalized impact which stimulates growth on an emotional as well as a cerebral level. While psychotherapy might be a very beneficial procedure for gaining such growth it is doubtful indeed whether most people would be willing, or for that matter need, to undergo so intensive a process in order to achieve a significant extension of self-awareness. Besides, the severe shortage

of psychotherapists makes it obvious that psychotherapy is, and probably always will be, out of reach for most of the population.

The potential value of the workshop in this neglected area of need thus seems obvious, especially when one considers that relatively large groups can be reached by this approach with a minimum of time and manpower.

My interest has recently been attracted to the possible clinical applications of the workshop. It is not unusual for clinic outpatients to wait many months before they can begin psychotherapy, and even after it is begun many patients find the treatment process so strange and unexpected that they often require many additional months before they learn how to collaborate productively with their therapists. With these considerations in mind I have conducted thus far five workshops with outpatients on waiting lists prior to their entrance into psychotherapy—three at the Kings County Hospital Mental Health Center and two at the Alfred Adler Consultation Center. These clinic workshops have varied in size from 18 to 30 members. Most of the participants were diagnosed as neurotics or character disorders. Although the outcomes of these pilot studies are still being evaluated, it would appear that the workshop method can be effective in generating self-insights and a degree of symptomatic relief, in overcoming resistance to group therapy, and in preparing patients for their collaborative role in treatment (6). (A mental health project grant from the National Institute of Mental Health is enabling further exploration in this area.)

The workshop could also be a useful training course for students of clinical psychology, social work and teaching. By comparing his reactions with those of others responding to the same workshop events, the trainee attending such a course

could sharpen his powers of observation, become more aware of the biases which influence his reactions, and increase his skill in assessing interpersonal events in which he himself is involved. In addition, the workshop experience could serve as a bridge between theory and practice, providing the trainee with real life opportunities to test out his understanding of psychodynamic concepts as he strives to explain and predict classroom events.

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Book Reviews

STUDYING THE INDIVIDUAL PUPIL

By Verna White

New York, Harper & Brothers, 1958. 238 pp.

Emotional factors significant in mental health are emphasized in this book by Dr. White. Some of the more frequent indications of the emotional problems of school children are, she says, "daydreaming, nail-biting, sullenness, kicking, swearing, telling untruths, stealing, bullying, and resentment toward authority." She warns, however, against misinterpreting certain kinds of emotional outbursts and "crying produced by frustration," which may, she says, be regarded as normal in the young child if the signs are not too intense and are not constantly manifest.

Basic in Dr. White's presentation is a specific point of view as to the primary objective of education today in the United States—that it is "to assist children to a happier, more satisfying life." This obviously involves a great deal of knowledge by the teacher of the children she has in her care. Measuring academic growth by means of standardized tests is not sufficient today, Dr. White says. "The teacher must attempt to gain answers to a series of questions for each pupil as the children enter the classroom," she asserts. What goals and aspirations does the child have? How acceptable are these goals and his means of attaining them? What aspirations do his parents have for him? How consistent are the problems he is contending with at home and in his social life? What are his needs and resources?

The author admits that there are no standardized methods of answering such questions as these, but in a final chapter she does set forth the competencies necessary for studying the individual pupil and

what this means in assisting children to a happier, more satisfying life.—W. CARSON RYAN, Chapel Hill.

EMOTIONAL DYNAMICS AND GROUP CULTURE

By Dorothy Stock and

Herbert A. Thelen

New York, New York University Press, 1958. 296 pp.

This monograph with an impressive title is subtitled "Experimental Studies of Individual and Group Behavior." It is the result of some five years of research into group operation by two investigators from the University of Chicago working from the National Training Laboratories (a section of the division of adult education service of the National Education Association). The aim was to contribute to the theoretical and practical understanding of the effects and control of social, emotional and psychological factors in group situations. Obviously, such research would be of value to educators, sociologists, the military service, industry and students of groups. They will find this monograph interesting, if they are technically equipped to plow through it.

The research is based on the concepts of W. R. Bion, who has written extensively upon the relationships in groups between work and emotional states, devised categories of emotionality, developed concepts of valence and of group culture or process. Valence is the individual's capacity for instantaneous combination with another for sharing and acting on a basic assumption. The group was to be studied as an organism.

A great deal of work and thought obviously have gone into this rather dry, academic monograph. If one is well equipped in his knowledge of statistics and educa-

tional theory, I'm sure this book would be easier to read. For the usual psychiatrist, even if he is interested in group practices, it is heavy going. One section which may be of some clinical interest attempts to translate into practical terms the major implications of the work on groups as social instruments. Problems such as the importance of group composition and size, what is required for maximum creativity in the group, whether a group needs a designated leader, whether there is any best leadership style, and whether member satisfaction is a sign all is going well, are discussed.

The discussion is stimulating but contains little or nothing that hasn't been written about before. It is important to document and research but in this instance I closed the book with the feeling that the mountain labored and brought forth a mouse. The psychiatrist can find more provocative, pertinent material on groups and probably the other disciplines also can.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

CLOSED RANKS: AN EXPERIMENT IN MENTAL HEALTH EDUCATION

By Elaine Cumming and John Cumming
Cambridge, Harvard University Press, 1957. 192 pp.

One of the first carefully controlled field experiments in attempting to change a community's attitude toward mental illness is documented in detail in this book. The experiment was something of a failure, and why and how this happened makes both interesting and instructive reading.

The community had not actively sought a mental health education program. Those who supervised the project, Elaine and John Cumming, sociologist and psychiatrist respectively, who also are the authors of this

book, were not connected with a local agency and therefore had no appropriate community base from which to operate. Unhappily, this effort at public education fostered not only resistance but actual hostility as well. By the time the project had ended, the gulf between the mentally healthy and the mentally ill had widened considerably. The population appeared to "close ranks," only too happy to push aside the mentally ill and forget about them.

In retrospect, the authors seriously question some of their original planning and the methods by which they were carried out. The fact that little had previously been done to chart the effectiveness of mental health education made the Cummings' original task all the harder, and they frankly discuss many of the pitfalls encountered.

The book is divided into three parts. Part 1 describes the character of the community, the kind of educational effort that was made and the general reaction to it. Part 2 gives in detail the methodology of the survey and statistical findings. In Part 3 the content is theoretical, analyzing those factors which went into the makeup of the study. The entire program, from the first survey of attitudes through the educational attempts and re-evaluation of the community feeling, is described clearly and concisely.

Many thoughtful implications can be drawn from the experiences delineated in this book, particularly as regards the social gulf between the mentally ill and the rest of the population and how this can affect the health of the community and the rehabilitation of those who are sick. Some aspects of the Cummings' experience were positive, such as the disclosure that public understanding can be increased, despite the admitted failure of the over-all project to reach its goals. Anyone concerned with the planning and carrying-out of community

programs, as well as persons who work with the mentally ill and their families, will find the book of extreme interest and help.—VICTOR BALABAN, Ed.D., National Association for Mental Health.

ALCOHOL AND THE JEWS

By Charles R. Snyder

Glencoe, Ill., Free Press, 1958. 226 pp.

The fact that the drinking practices of the Jews differs from those of other groups makes a scrutiny of Jewish drinking habits and the dynamic reasons for this difference of great interest to all who are concerned with the problem of alcoholism. The author has conducted a careful study of 73 Jewish men in New Haven, using the interview technique and supplementing it with data from questionnaires administered to 644 male Jewish college students. The latter are compared with Protestant and Catholic students. In considering the patterns, the roles of the ceremonial orthodoxy, regional background, generation, class and ingroup-outgroup relations are evaluated. Similar findings emerged in the two groups of Jews, using both techniques.

The author concludes that drinking pathology cannot be explained exclusively by individual psychology or by a craving for alcohol presumed to be physiologically determined but needs to be related to cultural traditions regarding drinking. He finds that where drinking is an integral part of the socialization process, is interrelated with the central moral symbolism and is practiced in the rites of a group, the phenomenon of alcoholism is conspicuous by its absence and sobriety can be sustained even though drinking is extensive. On the contrary, alcoholism may be expected to increase when there is disruption of tradi-

tional patterns in which drinking is integrated, when there is dissociation of drinking from the normal process of socialization and moral values, and where alcohol is used for purely individual purposes.

This report is of interest not only because of its intrinsic value but also because of the light it throws on the sociocultural approach to the study of drinking and other forms of behavior.—HERBERT S. RIPLEY, M.D., University of Washington.

MASTER YOUR TENSIONS AND ENJOY LIVING AGAIN

By George S. Stevenson, M.D. and Harry Milt.

Englewood Cliffs, N. J. Prentice-Hall, Inc. 1959. 241 pp.

This is a book about how to apply mental health principles to daily living, written for the average citizen by the man who is the foremost authority on mental health in our country, Dr. George S. Stevenson, in collaboration with his co-worker at the National Association for Mental Health, Harry Milt. That there is a public eager for its content has been made clear by the interest more than a million readers have shown in the authors' booklet, "How To Deal With Your Tensions", the precursor of this larger work.

Its purpose is to help men and women, regardless of differences of educational background, to understand how psychological tension operates—that they may take a fresh look at their own lives and be moved to act for their own improved mental health.

Beginning with an introductory picture of "This 'Shook-up' Age" and its hazards, the contents are divided into three parts.

Part I describes the origins of tension, shows its relationship to anxiety, and raises questions about how we may recognize excessive tension in our lives. Part II discusses eight methods of action for getting rid of tension. All of these involve feasible forms of either physical or deliberative action, such as talking it out, getting away for a change of perspective, and dealing with one problem at a time.

Part III considers ways to avoid tension-building situations in bringing up one's children, appraising one's job, and living with one's marriage partner. This portion is done especially well, with a naturalness that avoids ponderous psychological overtones.

The difficult task of writing a popular "how to do it" book in the intricate, many layered area of personality could have been mastered so successfully only by a psychiatrist and psychologist sufficiently sure-footed in their professional grounding, as are these authors, to be able to convey accurately psychological meanings with simplicity and ease. This book's writing is in clear, unpretentious language, buoyantly close to the popular idiom. It contains many illustrations of human beings living through familiar every-day situations.

The level of this book is mass education. In offering cues for self-help, the authors carefully indicate differences in degree of problems, pointing out situations in which readers may require help from qualified specialists. For the reading public the important thing is that this popular and excitingly written book is psychologically sound. It neither goads persons to strive for high levels of functioning they cannot maintain; nor does it overwhelm them with professional data they do not require. It does what it can to teach the feasible. EVELYN D. ADLERBLUM, School of Education, New York University.

PERSONAL, IMPERSONAL AND INTERPERSONAL RELATIONS

A Guide for Nurses

By Genevieve Burton

*New York, Springer Publishing Company, 1958.
230 pp.*

The student who takes advantage of the best that is currently offered in nursing education is given help in recognizing the interpersonal elements involved in a variety of clinical practice situations. Throughout the period of her college training she becomes increasingly well grounded in personality theory and in psychopathology. Under the guidance of her instructors she makes a careful study of interaction variously including patients, their families, herself and other personnel. Her observations are made not only in general and psychiatric hospitals but also in homes, schools and a number of different health agencies.

This book is intended primarily for practicing nurses who have not been so privileged as students and who may not be particularly motivated to serious study. Using simple language and many examples drawn from actual nursing situations, the author throws light upon a substantial number of interpersonal problems that nurses are likely to encounter in general hospital practice.

Emphasis is placed throughout the book on the nurse's need to recognize and accept individual differences in behavior, especially in expressions of feeling. The counseling role of the nurse is delineated without the use of technical terms, and again with illustrative anecdotes. The nurse is not neglected as a person in her own right. Motivations and attitudes commonly underlying the behavior of nurses become the focus of attention in a separate chapter as well as in other parts of the text.

By using them as basic to the structure of the book, Dr. Burton covers most of the topics included in the usual elementary course in personality development: psychosexual organization, socialization, conflict, anxiety, adjustment and the mechanisms of defense. The book's unique value, however, lies in the aptness and color of the many anecdotes it contains and the adroitness with which the author uses them to interpret theoretical concepts. One unforgettable narrative, the story of Danny and the croupette, which is used to illustrate (and incidentally to refute the concept of regression as an inevitable concomitant of illness) has all of the elements of high tragedy.—KATHLEEN BLACK, National League for Nursing.

GROUP PROCESSES

Transactions of the 3rd Conference
of the Josiah Macy, Jr. Foundation
October 7-10, 1956

Edited by Bertram Schaffner

New York, Josiah Macy, Jr. Foundation, 1957.
328 pp.

This is a carefully edited transcript of a Macy conference on "persuasion." To appreciate fully the richness of this material, the reader will need to be fairly well-oriented in the behavioral sciences. People with this background and a basic interest in human relations research will almost certainly be fascinated by it.

The title of the book is, in a sense, misleading. The "group processes" with which it deals most directly are interpersonal relationships. Group pressures and other forms of milieu control are examined from the standpoint of their effect upon individuals but not as factors in any kind of total group development.

The foreword by Frank Fremont-Smith, medical director of the Josiah Macy, Jr. Foundation, explains the purpose and nature of Macy conferences in general. The goal of this conference program is stated as "the promotion of (interprofessional and interdisciplinary) communication, the exchange of ideas, and the stimulation of creativity among the participants." Following the foreword is a lively series of autobiographical sketches introducing the members of the group, each a distinguished scientist in his own field.

Then comes the heart of the matter, in 4 chapters each containing a brief report of a piece of significant research and the discussion pertaining to it which took place in the meeting. Chapter headings are Interpersonal Influences within the Family, Interpersonal Persuasion (in a mental hospital), Further Studies on Maternal-Neonate Interrelationships, and Chinese Communist Thought Reform.

John Spiegel makes the first presentation, an episode from an interdisciplinary study that he and Florence Kluckhohn are conducting at Harvard on "the effects of conflicts between cultural value-orientations on the processes of interaction within a family and, consequently, on the development of healthy or pathological processes within members of the family." The protagonists in this incident are an Irish-American mother and a 16-year-daughter who is late coming home from a dance. Analysis of the interaction between these two reveals the extreme complexity of the situation: the conscious and unconscious motivation involved, the complementary structuring and restructuring of roles, the elements in the conflict (discrepancy) between the two personalities, the issues to be faced in the handling of the differences. Excerpts from records of two other cases in the study deepen the discussion.

This chapter is an excellent introduction to the second in which Erving Goffman, then with the National Institute of Mental Health, presents findings from his study of what went on in a state mental hospital between the patient and the institution as the latter attempted "radical resetting of the self-regulative mechanisms of the individual" (inmate). This section might well be required reading for professional staff in mental hospitals everywhere in this country. More research of this kind should help us all to find our blind spots.

The discussion in the third chapter is based on a film study of patterns of interrelationships between human mother and baby as the infant learns to nurse. In this and in related animal studies "persuasion" is defined as "potentiality for behavior which . . . draws forth biologically appropriate responses from other members of its population." The reporter here is Helen Blauvelt, who draws carefully upon biological studies of animal and human newborn now under way at Howard Liddell's behavior farm laboratory at Cornell and in Julius Richmond's department of pediatrics at the New York State College of Medicine in Syracuse.

In the fourth chapter, Robert J. Lifton of the department of psychiatry of the Harvard Medical School discusses the study of Chinese Communist thought reform that he carried on in Hong Kong from February 1954 to June 1955. Here, surely, is "persuasion" in its purest, most awful form! The self-defeating tactics of the mixed-up mother in Spiegel's case are depressing enough. The "backdoor" world of the mental institution, as Goffman pictures it, is a nightmarish thing. For sheer horror, however, it would be hard to find anything more spine-chilling to read than Lifton's description of the techniques that Chinese Communists have perfected for destroying

an established identity and replacing it with a different one.

And this, strangely enough, is all by way of saying that this report of the 3rd Macy conference on group processes is a thoroughly constructive, thoroughly scientific and thoroughly readable book. If the techniques of persuasion are sometimes used badly, it is still reassuring to know that interpersonal influence is a process that can just as well be studied as an instrumentality for the peaceful resolution of differences. Even now the behavioral sciences are in a position, as this conference shows, to provide some basis for the reorientation of leadership in certain strategic areas of our domestic and foreign policy. There are new and promising approaches to the broad problem of intercultural and international understanding. What can we lose by giving some of them a chance?

And, finally, in lighter vein: It was said, at the beginning of this review, that this is not a book about "group dynamics." Actually, there is one group very centrally involved in the experience reported—the conference group itself. There is a lot to be learned about persuasion in a scientific discussion on this level if one re-reads the book with attention focused on who said what, and when.—MURIEL W. BROWN, Social Security Administration, Washington, D. C.

HOME CONDITIONS: A SOCIO-MEDICAL STUDY OF 1,066 HOSPITALIZED PATIENTS WITH SKIN AND VENEREAL DISEASES

By Esbern Lomholt

Copenhagen, Rosenkilde and Bagger, 1958. 100 pp.

This paperback monograph presents statistical data and discussion of various socioeconomic factors in the environment of 1,066 patients who were attended on the service

of the Department of Skin and Venereal Diseases of Marselisborg Hospital, University of Aarhus, Denmark during the years from 1950 through 1953. Factors studied include age, sex, marital status, occupation, family income, mobility, overcrowding, alcoholism, family disorganization and broken homes.

Data obtained from medical and social histories were coded and placed on punch cards. Analysis reveals only two significant relationships between skin conditions and socioeconomic variables: atopic dermatitis occurred significantly more often in children from broken homes and ulcers occurred more often in men and women from poor homes.

This study further points to the complexities of psychosomatic mechanisms and the fact that very few simple linear relationships between causal agents and illness can be demonstrated. The authors state, for instance, in regard to one variable, that "irrespective of broken or unbroken homes, there is a relationship between emotional traumata and nervous complaints of all types." —WARREN T. VAUGHAN, JR., M.D., Western Interstate Commission for Higher Education, Boulder.

CONCEPTS AND METHODS OF SOCIAL WORK

Edited by Walter A. Friedlander

New York, Prentice-Hall, 1958. 308 pp.

In some 300 pages this book attempts to delineate the processes and ideology of social work along classic lines: casework, group work and community organization. The publishers claim that the book is "the first to bring into focus the dynamics of all three basic methods of social work." To my knowledge, this is true. And what makes

the book even more practical is that it has an enlightening chapter dealing with the usually overlooked or underplayed social work methods of administration and research.

Concepts and Methods is—and makes no pretense of being anything but—a whacking good textbook. The most complex ideas are held successfully to simple presentations; the case histories and their concurrently running analyses are particularly fine; the psychological and sociological working concepts are lucidly and uncomplicatedly presented. This does not mean that the book does not have its moments of profundity. It does. Undeniably, however, nuances, subtleties, fine interrelationships were consciously sacrificed for clarity and comprehension. It is a book the beginning graduate or undergraduate student can pore over profitably for hours. It has considerable merit as a refresher for the practitioner. As a lucid training tool, I believe it stands without peer.

But to the sophisticated reader or to the professional eye, *Concepts and Methods* possesses possibly much deeper implications. Here, unfettered by complex philosophies and unclouded by historical considerations, stands the thought and quality of social work. The nude, in this case, is singularly unattractive. She is pockmarked by vague theories and blemished by ill-defined methods; her form is a patchwork of paradoxes and contrasts—incomplete, half-formed, unfinished. That a vital organism is being represented there can be no doubt. But the faults, the failings—not the vitalism—keep coming through, for the technique concentrates almost exclusively on the unflattering minutiae. Highlighted, by implication, is the constant introspection, the limiting analysis, the strained logic, the prevalent sophism; lost is the vigor, the sweep, the drama that every practitioner

knows is an inherent (if sometimes implicit) part of social work's concepts and methods.

Let this be made clear: nowhere in this book—except in acknowledging possible gaps in knowledge—is the case consciously made against social work as a system of thought. But this absence, to the seasoned or skeptical eye, implies much more than any affirmation can. *Concepts and Methods* is remarkable as much for what it leaves unsaid as for the theses it avows.—JOSEPH L. TORRES, Missouri Association for Mental Health.

SELECTED WRITINGS OF JOHN HUGHLINGS JACKSON

Vol. 1: On Epilepsy and Epileptiform Convulsions

Vol. 2: Evolution and Dissolution of the Nervous System

Edited by James Taylor

New York, Basic Books, 1958. Vol. 1, 500 pp.; Vol. 2, 510 pp.

In 1931 James Taylor put all neurologists and psychiatrists in his debt by collecting for publication the most important writings of John Hughlings Jackson (1835–1911). Previously scattered in a multitude of journals difficult to find, they were collected in two volumes. The first contained all his papers on epilepsy, the second his more general writings on neurology and psychiatry. These two volumes have been out of print for some time, and the present publishers should be congratulated on reprinting them.

In reading of Jackson's work it is important to remember the flimsy neurological foundations he had to build on. In 1864, when he had already published 30 papers, few neurological diseases could be differentiated. Even anatomical localization of

disease was seldom possible. Most of the physical signs we use in neurology were unknown. Jackson used to say he had been in practice many years before the knee jerk was recognized. Apart from peripheral nerve injuries and one-sided paralysis from strokes and head injuries known since the days of Hippocrates, neurological diagnosis was rarely possible at that time. Out of this chaos Jackson and that group of late 19th-century neurologists of whom he was the greatest, devised an orderly approach to neurological diagnosis and laid the foundations of modern scientific neurology.

In the first volume are his papers describing the meticulous observation of epileptic seizures which led to the classification of various types of focal epilepsy: the "dreamy state" or temporal lobe attack, as we should now call it, and the focal motor attacks which bear his name. The clinical basis of cerebral localization, which he established but never overemphasized in physiological terms of function, was soon confirmed by the electrical stimulation experiments of Fritz and Hitzig in Germany and Ferrier in England. The earliest successful neurosurgery based on theoretical localization followed.

Inevitably some of Jackson's papers in the second volume have less significance today than others. There is little to be learned from the papers on vertigo save the ignorance of his time on that subject, though it is a sobering thought that even in those days Jackson distrusted the idea of dyspepsia as a cause of vertigo, a belief persisting to this day in some textbooks. Conversely, his stimulating papers on dysphasia remind one how little knowledge of this subject has progressed since his time.

Writing of Hughlings Jackson in the history of the National Hospital, Queen's Square, London, of which Jackson was the fifth physician to be appointed, Sir Gordon

Holmes said: "We find in his writings not superficial statistical reviews of a large material but the close study of a relatively small material. Nor was the recording of newly observed phenomena an end in itself for Jackson. Behind them he ceaselessly sought for the natural laws which they exemplified; this is the true philosophic method."

Those who study these classics of medical writing will see the truth of this assessment, and will recapture the excitement of his discoveries.—LEONARD D. OSLER, M.D., Boston University School of Medicine.

CURRENT TRENDS IN THE DESCRIPTION AND ANALYSIS OF BEHAVIOR

Nine lectures under the auspices of the University of Pittsburgh, March 11-12, 1955 and March 8-9, 1956

By Robert Glaser and others

Pittsburgh, University of Pittsburgh Press, 1958. 242 pp.

Each of the authors contributed one chapter—a lecture he gave at the University of Pittsburgh under the auspices of the psychology department. The lectures differ greatly in subject matter, scope, methods and manner of presentation.

Glaser describes, in very abstract and formal terms, the application of sociometry to small groups such as an artillery gun team. Zubin offers a model not for theories but only for the classification of certain observations and test results in tabular form, turning the clock back to the 1890's, on the ground that "the accumulation of isolated facts in psychopathology is impeding rather than accelerating progress." D. B. Lindsley writes about his own experimental animal work in electroencephalography, presenting

new knowledge about brain organization. Nowlis demonstrates how the effect of drugs can be measured through reactions to stories built around guilt and fear; he devotes much space to defining mood. Cofer deals with some problems in the transfer of learning from one situation to another. Guetzkow reviews, in general terms, the effect of a number of models on theory and methods in the field of interhuman relations. Carroll shows on the basis of his experiments how emotional clues or suggestions influence the use of verbs and sentence structure.

The last two chapters deal much more directly with psychopathological phenomena than do any of the preceding ones. Hamlin rightly emphasizes both the practical and theoretical significance of psychotherapy and the need to investigate it despite methodological difficulties. He points to some ways of overcoming the difficulties. He pleads against avoidance of significant problems because methods for their solution are still unknown. French briefly but succinctly reviews motives and their modifications under the influence of repression. These lectures omit those methods which are used far more frequently and effectively in the study of mental patients than most of the techniques described in this book. Only some current trends in behavior analysis are covered in this book.—ZYGMENT A. PIOTROWSKI, PH.D., Jefferson Medical College of Philadelphia.

RELIGIOUS DIMENSIONS OF PERSONALITY

By Wayne E. Oates

New York, Association Press, 1957. 320 pp.

This is a book that seems primarily intended as a textbook for theological students. Most of it is a compilation of theo-

logical information related to personality, and of psychological and psychiatric information regarding personality. At intervals the author puts forward his own interpretations and opinions. The information is rather loosely hung together, with insufficient integration. The interpretations and opinions are often well done. One wishes there had been more of them in proportion to the information. The author says, for example, that "religion and personality both defy adequate definition because they share the emphasis on the vital unity and indivisible totality of man in relation to himself, his attendant created order and the Creator; that "this insistence upon the uniqueness of man as an individual necessarily points man's religious quest in the direction of the discovery and realization of his individuality."

He frequently quotes Buber and Tillich, thus showing his debt to both Jewish and modern Protestant theology. He believes that the scientific conception of maturity is "a secularization of the religious conception of perfection and eschatology." He credits modern psychology with the "rediscovery of the intuitive depths . . . of the 'powers of darkness' which have been obscured by easy rationalistic kinds of thinking."

Those of us who started out in fundamentalism and have grown through various levels of religion and irreligion will appreciate his list of the "stages of religious maturity." He begins with the "religion of desire"—for example, for fertility, then that of "verbal interplay" with its "preoccupation with oratory and rhetoric," followed by the "religion of definition and exclusion," resulting in the "development of hierarchy." This stage leads to a "religion of rules" based on consolidation and conservation—soon resulting in rebellion and, may we devoutly hope, finally in the "religion of pure love."

Dr. Oates is unquestionably liberal in his outlook, in theological, psychological and racial matters alike. Since he is professor at Southern Baptist Theological Seminary this liberality is most refreshing. Despite the fact that some of his writings are rather turgid, both the theological and the psychological student can learn from his book a good deal of information about each other's views. With the help of his useful summaries and personal syntheses, each should broaden his own outlook and deepen his own thinking.—ROBERT A. CLARK, M.D., Friends Hospital, Philadelphia.

SYSTEMATIC SOCIOLOGY: AN INTRODUCTION TO THE STUDY OF SOCIETY

By Karl Mannheim; edited by
J. S. Erös and W. A. C. Stewart

New York, Philosophical Library, 1958. 169 pp.

This depiction of Mannheim's view of sociology is based on the manuscript of lectures given in London in 1934-35 and later years. The editors, two of his former research students, have reorganized the argument, rephrased the text and omitted a number of the lectures on concrete issues of social structure in order to restore Mannheim's original plan for a systematic sociology.

There are four parts to the book. Part 1, on man's psychic equipment, contains thumbnail sketches of behaviorist and psychonanalytic concepts, W. I. Thomas's "four wishes," the process of socialization, the nature of daydreaming, the effect of private property ownership on personality, and other topics. Part 2 deals with such matters as social contact and social distance, isolation, individualization, and competition and monopoly. Part 3, on social integration, has chapters on the sociology of groups and

"the class problem." Part 4, on social stability and social change, treats social control and authority, customs, law and other sources of stability, and contains a presentation and critique of Mark's theory of social change. There is an incomplete but serviceable index and a bibliography of titles, almost all from the 1920's and 30's, selected by the editors as most relevant to Mannheim's argument.

The positive sides of the book are the brevity with which an impressive array of the central ideas of sociology and psychology are presented, the vigorous promotion of the view that the two disciplines are indispensable to each other, and the glimpses offered of the healthy synthesis in Mannheim of clear thinking and involvement in the task of seeking solutions to the social problems of our time.

The weakness of the book, a substantial one, is that it serves no live purpose. As a presentation of systematic sociology it is both dated and too advanced for the beginner. For the advanced student it is deadened with the exposition of elementary concepts. It will be most useful to those interested in the nature and development of Mannheim's own views. Unfortunately, they will be handicapped by the fact that there are no footnotes, so it is not always easy to separate Mannheim's original thoughts from ideas which come from others.—KENT GEIGER, Harvard University.

PSYCHOANALYTIC STUDY OF THE CHILD, 1957

Edited by Ruth S. Eissler and others

New York, International Universities Press, 1957.
Vol. 12. 417 pp.

The twelfth volume of *The Psychoanalytic Study of the Child* continues the tradition of dividing the contributions in the following

sections: psychoanalytic theory, aspects of development, clinical contributions and applied psychoanalysis.

It is impossible to review, within the limited space, even the most outstanding contributions collected here. The beginning paper is one by Charles Brenner on the concept of repression. This is an excellent historical review of the changes Freud made in his psychoanalytic theories, which are discussed in connection with the topic. It is very useful for teaching purposes and it signals the beginning of many papers which will reinvestigate the individual defense mechanisms. We have in this volume, in addition, Jeanne Lampl-DeGroot's thoughts on defense and development, and Seymour L. Lustman's on psychic energy and mechanisms of defense.

Those who are interested in clinical aspects will find here a detailed discussion on the work done at Yale as part of a longitudinal study of children. This program was directed by Ernst Kris. The paper presented is by Marianne Kris, who continues his work. This is a very stimulating paper with many important references to development focused on an investigation into the use of prediction. The methodology is outlined and case histories presented. Kris feels that "this procedure is one of safeguards against the attempt to resort to oversimplified theories of personality development." This study highlights the interest in psychoanalytic research in studying infancy and early development not only from the viewpoint of the pathology but of general psychological laws. These volumes have dedicated a good deal of their space to the contribution of psychoanalysis to development and to psychoanalytic psychology.

There are a number of papers on adolescence: Nathan N. Root discusses a neurosis in adolescence; Elisabeth R. Geleerd, some aspects of psychoanalytic technique in ado-

lescents; Peter Blos, preoedipal factors in the etiology of female delinquency, and Margarete Rubin, delinquency as a defense against loss of objects and reality.

Some of these papers, as the title indicates, deal with individual cases; others attempt to make generalizations about this stage of development or about the generally applicable modifications in therapy.

Bela Mittelman continues to study motility, which he started many years ago. In this paper he investigates motility in therapy, particularly restriction of freedom of motility and awkward motility and its psychological meaning.

These are just some examples of the papers presented. The editors of this book obviously want to show the full range of psychoanalytic study of the child. It brings together theory and clinical findings, problems of techniques and investigation into applied fields. For all those interested in psychoanalysis, this volume too must be on your reading list.—PETER B. NEUBAUER, M.D., New York City.

THE BRAIN AND HUMAN BEHAVIOR

Proceedings of the Association for Research in Nervous and Mental Disease, in New York, December 7-8, 1956

Edited by Harry C. Solomon and others

Baltimore, Williams & Wilkins Co., 1956. 564 pp.

The subject of this volume should be of intense interest to both clinical neurologists and psychiatrists and most of those basic scientists working in the laboratories and clinics of our institutions, such as psychologists, biochemists and neurophysiologists. In the introduction by the senior editor, Harry C. Solomon, the subject is defined as a challenging and intriguing one.

It was stated that philosophical and psychodynamic aspects were purposely omitted. This reviewer considers that the omission of a mature, thoroughly experienced philosopher who could provide the necessary background to the dichotomy of concepts between so-called brain and mind was unfortunate. Even if such an authority were only on the commission his comments in the discussion would have been invaluable. Indeed, the first paper by the late Karl S. Lashley, perhaps the most stimulating paper in the whole volume, tries to cover this problem of the philosophical background of these relationships. Such aspects of behavior as the will, memory, experience and insight, were touched on by Lashley in an interesting and scientific manner.

Although the text suggests that the papers will be limited to human behavior, one of the longest papers therein is largely devoted to the interpretation of motor behavior in monkeys who had lost, through surgical means, various areas of their cerebral cortex. This paper is an exceedingly valuable part of the book, however, and Denny-Brown and Chambers are to be congratulated on the completeness of this study.

The long psychological investigations by Lacey concerning autonomic activity are difficult to comprehend in relation to the total subject. An equally long paper by Wolff and associates covering much of the same material in different neurologic states in relationship to stress is much better presented.

There are a number of papers, notably one by Penfield and another by his psychologist, Milner, showing the deficits and alterations produced by removal of cortex in humans. Interesting papers on the electrical responses from deep areas of the brain in various neurologic states, as well as a number of carefully documented contributions on the effects of various drugs on hu-

man behavior, furnish difficult but very worthwhile reading.

Inasmuch as the volume was not limited entirely to human behavior, it is too bad that an authority like Professor Lorenz of Germany could not have been included in the group to add his tremendous knowledge of abnormal and normal behavior of a variety of animals under different environmental conditions.

This volume has surely pointed out the little we know about the higher function of the human brain.—ROBERT S. SCHWAB, M.D., Massachusetts General Hospital.

ONE MARRIAGE—TWO FAITHS

By James H. S. Bossard and
Eleanor Stoker Boll

New York, Ronald Press, 1958. 180 pp.

It was indeed a pleasure to read this book since it presents not only the scientific data of a sociological study, based on years of experience, but the application of human understanding and feeling to these observations. The style of the presentation lends itself to easy reading by the average intelligent layman, and also makes for interesting reading by the professional worker in the field of marriage counseling.

In a topic which can be clouded with much biased opinion and controversy, it is a tribute to the authors that they maintain a neutral attitude acceptable to all religious faiths and yet proceed to analyze the problems of interfaith marriages in a forthright and logical manner.

The authors emphasize their opinion that faith and religion represent a certain culture or subculture with all its traditions and mores; that bringing together in marriage a man and a woman of different faiths always implies additional stresses and strains

because of the problems involved in attempting to harmonize different cultures. These problems become more evident after the honeymoon phase is passed, and are manifested by disturbances in sexual relationships, the development of hostilities between the marital partners and difficulties in family and social relationships. All of these problems are further magnified by the appearance of children in the family, and by everyday economic problems.

The presentation of illustrative case material and the official views of the major religious denominations is to be commended.

One drawback of the book is the lack of emphasis placed upon the role of unconscious forces and conflict in marriage problems, thus limiting its value for the more serious or sophisticated student working in the field. However, it should be on a required list of reading for persons of different faiths planning marriage to each other.—BERNARD M. PACELLA, M.D., New York City.

PSYCHIATRY FOR NURSES

By Louis J. Karnosh and
Dorothy Mereness

St. Louis, C. V. Mosby Company, 1958. 5th ed. 406 pp.

The fifth edition of *Psychiatry for Nurses* continues its role in nursing education that the four previous editions established.

It is an attractive volume printed on glossy paper. The subject matter is presented in 36 chapters with an index and a glossary.

The introductory chapter defines psychiatric nursing, and the nurse's need to understand herself and her role in psychotherapy is explained.

Chapters 2 through 4 review the development of man's understanding of mental

illness, and the present-day concept of the significance of heredity in such diseases is briefly outlined.

Chapters 5 through 9 define the structure of personality and the correlation body build with mental characteristics according to recent formulations. An abbreviated classification of mental diseases with nomenclature adopted by the American Psychiatric Association in 1950 provides authentic data.

Chapters 10 through 26 outline psychiatric disorders according to the diagnoses. Patient behavior is depicted and the nursing objectives in various manifestations of disturbance are included.

Case studies of individual patients are used to depict some significant symptom. Functional, organic, infectious and traumatic illnesses with their characteristic manifestations are described. Mention is made of epilepsy, mental retardation and personality disorders. The nurse may not meet these in a hospital for mental diseases but she may encounter them in general hospital situations or elsewhere and she should be prepared to interpret the behavior deviations observed.

Psychosomatic manifestations of illness may also occur in patients in general hospitals. The concepts underlying therapy employed is explained so the nurse may understand the purpose.

This fifth edition brings up to date the modern use of old drugs and new synthetic compounds employed in psychiatry. Psychosurgery and the need of retraining patients is particularized appropriately.

The reading lists following the various chapters are mostly taken from material published since 1950. Some exceptions are important background classics, currently used.

The diagrams used to illustrate physiological references are clear and helpful. The

photographs of patients, illustrating behavior mannerisms, have been carried over from previous editions. Some of these are unnecessarily unsightly and could be advantageously omitted.

The text is intended to be used by student nurses and should be helpful as an adjunct to lectures and supervised practice.—MARY E. CORCORAN, Riverside, R. I.

EDUCATION OF THE CLINICAL SPECIALIST IN PSYCHIATRIC NURSING

Report of a national working conference at Williamsburg, Va., November 26-30, 1956
New York, National League for Nursing, 1958. 80 pp.

This book will be surprising and quite enlightening to those people who have felt that the principal trend in nursing today is away from clinical services and toward administrative and educational duties. It describes the role of the clinical specialist (perhaps "expert practitioner" would be a better term); discusses some of the ways in which the nurse participates in or carries out therapy; outlines the educational program which might prepare a nurse for such work; and speculates on the future of this newborn profession.

The events in the last quarter century, beginning with insulin and including World War II and the tranquilizers, brought about an almost explosive expansion of psychiatric practice. This subjected nurses to many demands for which they were inadequately prepared. About ten years ago the National League for Nursing obtained funds from the National Institute of Mental Health with which to explore ways by which education in psychiatric nursing could be improved. The earlier conferences were mainly concerned with administration, supervision, consultation, research and teach-

ing. The one reported in this book was intentionally limited to the nurse directly engaged in patient care.

While this book reiterates the traditional concept that nurses complement doctors and do not propose to replace them, it does see the nurse as being in the key position to influence the total living experience of the patient. She is expected to maintain a therapeutic environment and to influence the patient's behavior by her own. To do this, the nurse must be mature, well integrated, skilled in communication, and knowledgeable in the dynamics of behavior. This, in the opinion of the conference, calls for education at the master's degree level.

For the future, the conference concluded that the highly skilled psychiatric nurse who

does not administer or do formal teaching will find difficulty in many institutions which are functioning along outmoded lines. She will also run into the policy (so thoroughly fixed in civil service) of rewarding administrators rather than performers, but she will in time make a place for herself.

The conferees included psychiatrists, psychologists, social scientists and nurse administrators as well as nurse educators. They were well aware that now and in the near future very few nurses with master's degrees will be doing bedside nursing. However, as a blueprint for what ought to be and as a guide for future planning this book will be referred to and quoted as a most significant document.—GRANVILLE L. JONES, M.D., Little Rock.

Notes and Comments

MENTAL HEALTH APPROPRIATION

Congress has appropriated \$68,090,000 for the National Institute of Mental Health in 1960—\$15,706,000 more than the President requested. It was, however, \$6,000,000 less than the amount recommended by the National Association for Mental Health.

Paul Johnson, NAMH legislative committeeman, when he testified before subcommittees of the House and Senate last spring, asked \$74,000,000 for NIMH—the increase to go for more training, community mental health services, professional and technical assistance, research projects, grants and fellowships.

Of the sum voted by Congress, \$23,482,000 will go for research grants, including \$3,800,000 for the mental health projects grants program (Title V) and \$6,500,000 for the psychopharmacology program. This gives the Institute \$6,553,000 more than was available last year for grant-supported investigations into the cause and cure of mental diseases.

In addition, \$7,572,000 has been appropriated for research to be carried on in NIMH laboratories—\$896,000 more than was allocated for the same purpose in 1959—and the sum for research fellowships—\$1,996,000—represents an increase of \$851,000 over the previous year's allowance.

Programs for training mental health personnel will receive the largest boost—\$7,993,000 more than the 1959 sum, or a total of \$26,206,000. Included in this total is \$2,300,000 for general practitioners who wish to take postgraduate psychiatric training or psychiatric residency training.

NIMH was also given \$5,000,000 for grants to the states, to help them in developing community mental health services;

and \$1,938,000 for professional and technical assistance to the states.

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The House appropriations committee report regarding this bill gave reasons for the increased appropriation:

"Recent figures presented to the Committee indicate that mental illness costs this country a minimum of \$3 billion a year.

"Despite the staggering economic losses, the Committee received heartening evidence of remarkable progress against mental illness. . . . At the end of 1958 there were 52,000 fewer mental patients in all mental institutions than might have been expected on the basis of the rising curve from 1945 to 1955.

"Just the annual money savings resulting from this reduction amount to much more than this entire appropriation if calculated on the most conservative basis. It costs an average of \$1,500 a year to provide little more than custodial care for each patient in a mental hospital and in institutions where good care and service is given the costs are much higher. Restored to a useful life this same person is earning his own living and paying taxes.

"Medical research that can increase our ability to prevent chronic mental illness is the only way of eventually cutting down on the nation's multi-billion dollar annual bill for care of the mentally ill."

The committee report also summarized recent research developments, including the use of new drugs and studies of the psychological aspects of mental illness. It noted that critical shortages of psychiatric personnel have impeded the successful treatment and recovery of the mentally ill—thus explaining the unusually large increase devoted to training programs.

Begun in 1959, the program for giving psychiatric training to general practitioners, the committee reported, has been "received with unprecedented enthusiasm by the medical profession. . . . Since the family physician is dispensing the greatest quantity of the new drugs, it is absolutely vital that he receive the psychiatric education he so avidly seeks. It will be expected that this program be expanded in 1960."

A separate section of the report, on juvenile delinquency, recommended research into "the psychological, emotional and environmental factors leading to deviant behavior in youth. From such knowledge can come means for preventing juvenile delinquency." It was suggested that the federal Children's Bureau and the NIMH should collaborate in such studies. "Accordingly, the Committee calls upon the National Institute of Mental Health to use such portions of the increased 1960 funds as may be necessary to undertake a most careful and thoughtful study of what can and should be done . . . in the field of juvenile delinquency." The committee also asked for a report from NIMH on its proposals for future action.

JUVENILE DELINQUENCY

Answering the directive of the House committee (see the item immediately above), the National Institute of Mental Health reported on its present juvenile delinquency program. The report stated:

"The Institute currently has a large-scale program of intramural research relating to children, and is supporting almost 200 extra-mural research projects concerned with children. . . . The majority of these projects are in the areas of mental retardation, delinquency, and other forms of deviant behavior in children, but the largest single category of projects is in the area of child development. . . .

"Specifically in the area of juvenile delinquency, the NIMH conducts a program of research, training, and consultation in the mental health aspects of delinquency."

Among the extra-mural research projects on delinquency which it is supporting are three described in detail in the report:

1) At the University of Michigan, "a community study focused on the psychological and social factors involved. It includes a study of middle class as well as lower class delinquents among both white and Negro youth, and is to culminate in an experimental delinquency prevention and treatment program."

2) At the South Shore Courts Clinic in Quincy, Mass., "investigators are attempting to classify into recommended treatment categories a sample of all delinquents coming to the juvenile court. This effort is based upon the evidence that disposition or treatment of delinquents is determined for the most part throughout this country by persons untrained in mental health or human behavior disciplines. It is hoped that findings from this project will permit treatment classification procedures which can be applied by at least some of such untrained or partially trained persons. Tentative findings from the pilot phase of this project indicate that at least half of all delinquents coming to the court merit intensive mental health or social work treatment."

3) At New York University, a project based on "the conviction of many experienced delinquency specialists that the provision of adequate treatment and preventive services in a high-delinquency area will now reduce the problem within tolerable limits . . . Dr. Chein of New York University has completed several years of valuable research on the psychosocial correlates of juvenile drug addiction and delinquency, and is convinced that such a

large-scale service project would be effective. He has designed such a project and the current grant is financing his exploration of the feasibility of this project or a similar one in New York City."

PSYCHIATRIC TRAINING FOR PHYSICIANS

One example of how NIMH is using its increased funds is the three-year grant of \$68,364 awarded to the Western Interstate Commission for Higher Education to conduct a regional program of post-graduate psychiatric education for western physicians. The aim is to augment the ability of local physicians in the early detection and control of mental illness and improve their skills in the rehabilitation of ex-mental patients.

Dr. Warren T. Vaughan, Jr., WICHE mental health project director, said regarding the award: "In the face of the critical shortages of psychiatrists, it is obvious that most psychiatric conditions will have to be handled by the practising physician in the patient's own community. Many parts of the West are without psychiatric services. As a result, the level of psychiatric service available to the people in these areas will be determined by the psychiatric knowledge and understanding of the local physicians. We see this new WICHE program as a demonstration that greater use can be made of existing resources to ease, in part, the shortage of psychiatric manpower."

The program has been designed as a seminar meeting once a week for 10 weeks; students will be pediatricians, surgeons, internists and general practitioners, discussing typical psychiatric problems encountered in medical practice. Each seminar will be led by two qualified psychiatrists who will also be available for direct consultation by the participating physicians.

These study groups are being set up in

four cities each year (12 western cities will be included in the three-year program) by the faculty of the Langley Porter Neuropsychiatric Institute, San Francisco, in cooperation with the WICHE mental health council. For the first year, Lebanon, Ore., Laramie, Wyo., Phoenix, Ariz., and Billings, Mont. will be the sites of the weekly seminars.

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Another phase of the NIMH program to encourage this trend—post-graduate psychiatric training of physicians—is the American Psychiatric Association's general practitioner education program, which NIMH is supporting with a grant.

William F. Sheeley, M.D., formerly of Minneapolis, was appointed to head this program at the APA headquarters in Washington, D. C. He and his associates are now developing the content and form in which such training can be brought to family physicians in their own communities.

Dr. Sheeley, 42, was in the Army and Air Force from 1942–1955, serving as a flight surgeon, an intelligence officer, and in aero-medical research. He did graduate work in psychiatry at the University of Minnesota and was certified by the American Board of Psychiatry and Neurology in 1955. Thereafter he served for two years as acting superintendent of Hastings State Hospital in Minnesota, and was chief of psychiatry at Minneapolis General Hospital, also assistant professor of psychiatry at the University of Minnesota.

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A southern conference—indeed, the first regional conference on the training of physicians in basic psychiatric principles—was held in Atlanta, October 8 and 9, 1959, with delegates from 16 southern states.

Sponsored by the Southern Regional Education Board, the conference presented speakers who are key men in the fields of

medicine and psychiatry. They discussed the incidence of emotional and psychological disturbances in a physician's practice; the need for general practitioners to understand these disturbances; and successful programs now used in teaching physicians these basic psychiatric principles.

Dr. John G. Walsh, president-elect of the American Academy of General Practice, opened the meeting with a discussion of the practitioner's responsibility to his patients in the matter of emotional and psychiatric symptoms related to an illness.

"Patients want the old-fashioned kind of doctor who treats the whole person," said Dr. Walsh. "Modern specialization has cost us the personal touch between doctor and patient."

He said a large percentage of any doctor's patients come to him with disturbances which need some psychiatric consideration, but which can be handled outside of a psychiatrist's office.

Dr. Robert H. Felix, president-elect of the American Psychiatric Association and director of the National Institute of Mental Health, cited a number of specific illnesses which involved psychological or emotional problems. Among these he included obesity, diabetes, heart diseases, and ulcers.

The secret of medical practice is in caring about a patient while you care for him, said Dr. Leo H. Bartemeier, medical director of the Seton Institute and chairman of the Council on Mental Health, American Medical Association.

He suggested that psychiatric training begin with medical students at a time when emphasis on the scientific method tends to overshadow the young doctor's relation to his patient.

Dr. Raymond Feldman, director of the training and standards branch of the National Institute of Mental Health, discussed training funds available from the NIMH

for post-graduate courses and to help schools improve their teaching of psychiatry.

One of the final discussions was a sampling of successful post-graduate programs used throughout the country, ranging from individual discussion groups to formal, region-wide programs for physicians in the southern states by Dr. William Rottersman, Atlanta psychiatrist. Dr. William P. Hurder of the Southern Regional Education Board offered the SREB as a secretariat-sounding board-evaluating agency in implementing any regional program.

NEW DIRECTOR OF NAMH

The new executive director of the National Association for Mental Health, Lawrence J. Linck, took office on September 1. Word of his appointment came too late for inclusion in the October issue of *Mental Hygiene*.

Mr. Linck has had a long and distinguished career in the health and welfare field. He was executive director of the National Society for Crippled Children and Adults from 1945 to 1956. From 1940 to 1945 he served as executive director of the Illinois Commission for Handicapped Children, and from 1941 to 1945 as director of the University of Illinois Division of Services for Crippled Children.

From 1956 until he accepted his new post, Mr. Linck was a professional management counselor with offices in Chicago, serving corporations, associations and foundations in the U. S. and Brazil.

He has been a special consultant to the U. S. Public Health Service, and consultant to the Office of Vocational Rehabilitation in the U. S. Department of Health, Education and Welfare; member of the Committee for the Handicapped, the People to People Program; and editor of *The Crippled Child* magazine. He has also served

as a member of the National Advisory Committee on Maternal and Child Health of the U. S. Children's Bureau and the National Commission on Children and Youth.

The new mental health executive previously held lectureships in the College of Medicine of the University of Illinois, the Institute of Social Administration at Loyola University and University College of Northwestern University.

He is presently chairman of the committee for the 8th World Congress of the International Society for the Welfare of Cripples, to be held in New York in 1960. He is also treasurer of the International Society for the Welfare of Cripples and trustee-at-large of the National Society for Crippled Children and Adults.

In announcing the appointment, Judge Luther Alverson, president of the NAMH, said, "We are very fortunate to have Mr. Linck as our executive director. His long years of service and experience in the health and welfare field will bear directly on our work and will help our organization develop new momentum in its fight against the nation's number one health problem—mental illness. His leadership in the administrative field should prove invaluable, too, in helping our 800 state and local affiliates to increase their service to the people in their communities, and in bringing many hundreds of new affiliates into being throughout the country."

INTERSTATE COMPACT

Twenty-two states have now ratified the Interstate Compact on Mental Health, which provides that hospital care and treatment for the mentally ill shall be given to each person who needs it even though he may legally be resident in another state. It also permits the transfer of a mental patient to an institution in

another state when such transfer would be in the patient's best interest; and provides interstate cooperative machinery for after-care or supervision of patients on convalescent or conditional release.

At the last meeting of its legislature, Ohio became the 22nd state on the list. Others which had previously ratified the Compact are: Alaska, Arkansas, Connecticut, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Vermont and West Virginia.

MORE FUNDS FOR MENTAL HEALTH

A new peak of \$64.8 million in federal, state, and local funds was budgeted by the states for community mental health services in 1959, according to the National Institute of Mental Health. The total represented a 20% increase (\$10.8 million) over the funds devoted to this purpose during the previous year. Most of the money was spent for increasing staff, research and training; about \$9 million was used for clinical and local mental health services.

AGING

Preparations for the White House Conference on Aging, to be held in January 1961 at Washington, D. C., are well underway. Secretary Arthur S. Flemming, of the Department of Health, Education and Welfare, has named seven regional representatives, and two more will be appointed later. They are to assist states and communities in their regions to prepare for the Conference. The White House Conference staff and the Department's special staff on aging, both directed by William C. Fitch, are now preparing background papers, pamphlets and booklets for use at community, state and regional meetings

which will be held prior to the Washington conference.

Secretary Flemming has also named 130 outstanding citizens to serve on the national advisory committee for the conference. The committee chairman is former Congressman Robert W. Kean, of New Jersey.

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Aging was also listed as one of the areas of major interest for World Mental Health Year by the World Federation for Mental Health at its annual meeting in September.

PUBLIC HEALTH OFFICERS

Consolidating community public-agency services concerned with physical and mental health was advocated by the long range planning subcommittee of the Association of State and Territorial Health Officers, which met in Washington, D. C., October 15-16. A draft report submitted to the Association outlined the recommendation:

"While there may be at state level some dispersion of official responsibility for medical and health programs, this Association holds strongly that at the local level there should be a consolidation of all community programs concerned with health, physical and mental. . . . Local health departments should be so strengthened that the local services for physical and mental health needed by various state agencies could be provided through a consolidated local program."

The committee also recommended that responsibility for physical and mental health, aside from institutional care, be unified in public health programs of the future:

The Association urges a re-evaluation of the inter-relationship of health programs for the protection and promotion of physical and mental health. It recognizes that activities in mental health in their development frequently were associated with

programs for the hospital and clinic care of the mentally ill. The extension of public mental health from this source has resulted in a division of the health program. At first this seemed not unnatural since when this new public health program was initiated there was so little in common in the training of those concerned with mental illness as compared with those working in the general public health program. It is the view of the Association that the hospital care of the mentally ill advantageously can be handled separately, but that otherwise problems in physical and mental health in the individual and in the community are inseparably intertwined. It is strongly recommended that in the public health program of the future the non-institutional responsibility for physical and mental health be unified. This will demand an extension in the training of public health workers (particularly of health officers and public health nurses) in the behavioral and social sciences. Also to the already multi-disciplinary staff of health departments, there will need to be added those with specialized training in the social sciences who will need also sound training in general public health. A firm acceptance of the ultimate goal of the unification of community programs in physical and mental health, but a readiness to move toward it through a gradual transition, is recommended.

Reactions of Association members to these recommendations varied from approval to strong criticism. Here are some of the comments:

"A shying away from responsibility for institutional care of the mentally ill is noted. It would seem that the institutional program and the community program are inseparably intertwined. In view of this health departments might reconsider their future potential roles in the institutional

care of the mentally ill." "This (separation of hospital care) fragments the patient's care and makes continuity more difficult."

"We support this merger because in a small state such as ours we do not need a separate Department of Mental Health. All individuals and groups who support mental health in the community have argued for integration and consolidation of the mental health program. In fact, many of them have recommended that there be a separate Department of Mental Health integrating the institutional and community program, taking the latter program away from the Department of Health."

YOUTH

Juvenile delinquency tops a list of 40 major "areas of concern" reported by 45 of the state committees preparing for the Golden Anniversary White House Conference on Children and Youth. This conference, with 7,000 participants will be held in Washington, D. C., March 27 to April 2, this year.

In every state, also the District of Columbia, Puerto Rico, Guam, American Samoa and the Virgin Islands, a committee appointed by the governor is preparing a report on existing services and unmet needs affecting young people; these reports, now being analyzed at Conference headquarters, will be published for use at the Conference.

A questionnaire answered by these state committees has shown that 45 states are most concerned with prevention and treatment of juvenile delinquency. Next on the list is the problem of emotionally disturbed children, listed by 32 states. Other major concerns in the order of their importance, are: retarded children (treatment and training); religious and spiritual life

of children; establishing values and ideals in children.

Called together by President Eisenhower "to see that we prepare today's children well for life in tomorrow's world," this will be the sixth decennial White House Conference on Children and Youth held since 1909. President Theodore Roosevelt called the first one; and its continuing activity has influenced such forward developments as federal and state child labor laws and establishment of the Children's Bureau.

"The Conference is more than a five day meeting in Washington," said Ephraim R. Gombert, executive director of the Conference. "It is an 11-year process of study and action—one which has already commenced in every state and will continue until the next Conference in 1970."

MENTAL RETARDATION

Congress has appropriated \$1,000,000 for the expansion of education for mentally retarded children. The Commissioner of Education will use this sum to make grants to public or nonprofit institutions of higher learning for the training of professional personnel who in turn will train teachers of mentally retarded children.

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Today 44 states have programs for the retarded, according to the National Institute of Mental Health, whereas five years ago only four states had such programs. Growing interest in providing services for the retarded has led 20 states to set up legislative commissions to study their needs.

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A possible relationship between virus illnesses in infants and mental retardation later in their lives has been indicated by research at the North Little Rock, Ark., Veterans Administration hospital and the University of Arkansas Medical Center.

Researchers Dr. Carl E. Duffy, professor

and chairman of microbiology at the medical center; Dr. Oddist D. Murphree, chief of the VA hospital's research division; and Dr. Thomas T. Frost, the division's chief pathologist, working with laboratory animals, have found that a virus infection acquired early in life can have an adverse effect on the development of the nervous system—and thus affect an individual's learning ability. They believe that virus infections can be blamed for some of the cases of mental slowness in which heredity previously was considered the controlling factor.

The older the animal, according to these scientists, the less effect virus infections had in causing retardation. Animals eight days old when inoculated with a virus inducing illness were far slower mentally than those inoculated when they were 14 days or older.

This animal research lays the foundation for clinical research to be done later on humans.

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"Education of the Severely Retarded Child" is a bibliography of more than 300 titles published by the Office of Education. Only a few of the titles listed were published before 1950. Copies may be obtained from the Government Printing Office for 15¢ each.

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"Success in Employment of Educationally Subnormal Children," an article by J. E. Collins, B.A., Ph.D., Dip. Ed. Psych., in *The Medical Officer* (London), October 2, 1959 issue, reports on a study of the children who left Pencalenick Residential School between 1952 and 1958. Dr. Collins reports that 57% were successful in employment in an area where unemployment figures are considerably higher than the national average.

"This investigation suggests," he writes,

"that success in employment of educationally subnormal children may be linked with levels of intelligence, attainments at the time of leaving school and with home conditions."

DIRECTORY

The 1960 Directory of American Psychological Services is an enlarged and approved list prepared and distributed by the American Board of Psychological Services, Inc. (The earlier edition was reviewed in *Mental Hygiene*, April 1959.) The list comprises 176 individuals and services in the United States and four in Canada that have applied for listing and meet the qualifications of the American Board of Examiners in Professional Psychology. In addition to the standards for Diplomate status, the directory presents a geographical list of the Diplomates of the A.B.E.P.P., Glendale, Ohio. Price \$1.50.

RIGHTS OF CHILDREN

A United Nations charter for the world's children was formally approved by the General Assembly's Social, Humanitarian and Cultural Committee on October 19, 1959. Among the principles enunciated by the Declaration of the Rights of the Child, these concern mental health:

"The child shall . . . be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. . .

"The child who is physically, mentally or socially handicapped shall be given the special treatment, education and care required by his particular condition.

"The child, for the full and harmonious development of his personality, needs love

and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and in any case in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. . . .

"He shall be given an education which will . . . enable him on a basis of equal opportunity to develop his abilities, his individual judgment and his sense of moral and social responsibility. . . .

"He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood and in full consciousness that his energy and talents should be devoted to the service of his fellow men."

WFMH NEWS

The 13th annual meeting of the World Federation for Mental Health will take place in Edinburgh, Scotland, August 7 to 12, of this year. Theme of the meeting will be "Action for Mental Health."

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Peru was one of the first countries to allocate funds for the promotion of national activities for World Mental Health Year, and is the first country of the world, according to WFMH, to give official recognition to the Year. A government statement, issued in Lima in June of last year, promised that "the Council for Mental Health will be responsible for the carrying out of inquiries on a national level in the field of mental health and the study of the sociological aspects of industrial development in relation to mental health; and that the result of this work shall be made known in the scientific meeting which shall be convened at an appropriate time as a contribution from this country to the activities of World Mental Health Year."

At a meeting of the U. S. Committee of the WFMH, Dr. John R. Rees, British psychiatrist who is director of the Federation, reported that mental and emotional disturbances are increasing in underprivileged countries as well as in the "over-privileged western nations." He said the increase in the poorer countries "probably is linked with rapid industrialization and change which disturbs existing cultural patterns."

William T. Beaty, II, assistant executive director of the New York State Association for Mental Health, was elected president of the Committee; Mrs. Grace E. O'Neill, general secretary; Mrs. Charles S. Ascher and Mrs. Jonathan Bingham, vice presidents. Honorary presidents Mrs. Clifford W. Beers, Dr. Earl D. Bond, Mrs. Henry Ittleson and Dr. Arthur H. Ruggles were re-elected. The other officers elected at this meeting are: Mrs. Jonathan Bingham, chairman of the governing board; Mrs. George A. Stern, chairman of the executive committee; Dr. Robert L. Sutherland, treasurer; and Dr. George S. Stevenson, assistant treasurer. Dr. Margaret Mead, Dr. Bertram H. Schaffner and Lewis Cullman were elected to the governing board.

NEW SCIENTIFIC COMMISSION

The Commission of Neurochemistry, of the World Federation of Neurology, met for the first time at the Institut Bunge in Antwerp, Belgium, September 29 and 30, 1959. Neurochemists from Germany, Sweden, England, Netherlands, Belgium, England, Canada, and the United States, twelve in all, were invited and constituted the original Commission. They named Dr. A. Lowenthal, of Antwerp, as secretary; and agreed to establish a permanent secretariat at the Institut Bunge. A symposium on neurochemistry will be held in Rome during the Congress of Neurology of 1961.

SURVEY OF MENTAL HEALTH RESEARCH

The Southern Regional Education Board has made a state-by-state survey of mental health research, including research in mental retardation. Results of the survey, transferred to IBM cards, provides information on current work in progress in the south, and how it is being carried out, also an all-over look at the south's resources and needs in such research. This data was presented to a meeting of educators, legislators and researchers in November, 1959, and is now available from SREB to all interested persons.

SREB AWARDS

A program to enable mental hospital and related personnel to observe and acquire training in new mental health programs conducted by other institutions in the country was set up by Southern Regional Education Board in 1958 with a grant from the National Institute of Mental Health. Since its inception, the Board has made awards to over 100 employees of mental hospitals and training schools in 11 southern states for visits to other institutions in 22 states and Canada.

COLLEGE STUDENTS HELP MENTAL PATIENTS

Washburn University students are helping to provide a new therapy at the Topeka, Kans., Veterans Administration hospital. They offer companionship to mental patients in the activities available at the hospital—bowling, swimming, riding bicycles, shop work, playing cards, and other games and sports.

Ten students are participating; each spends about two hours a week with the patient assigned.

"We chose college students because they are youthful, energetic and vigorous," said

Dr. R. G. St. Pierre, hospital manager. "We selected patients who, we felt, could benefit from close companionship and taking part in activities with an interested person."

NEW PSYCHIATRY SCHOOL

The New York School of Psychiatry, a graduate school offering basic and advanced psychiatric education, has been opened by the New York State Department of Mental Hygiene for its medical personnel.

Offering a three-year training program, the school operates under a provisional charter granted by the Board of Regents of the University of the State of New York. It serves the staffs of Brooklyn, Creedmoor, Kings Park, Pilgrim and Central state hospitals and Willowbrook State School.

Similar graduate training is provided by the Department in cooperation with medical schools for other state hospitals. The program is intended to provide instruction for physicians planning a career in public psychiatric hospitals or mental health clinics; and to insure the specific training required for such positions. The program also serves as a means of recruiting psychiatric personnel for the institutions administered by the Department.

Eligibility depends on the following requirements: graduation from a medical school acceptable to the New York School of Psychiatry; completion of at least one year of internship at a hospital acceptable to the school; and appointment as a resident or staff member at one of the associated state mental institutions.

Instruction includes a basic curriculum in psychiatry, requiring two years, and advanced curriculums in specialized areas. The school is in the medical-surgical building of Manhattan State Hospital on Ward's Island, and includes an out-patient clinic. Students, closely supervised, will work with

hospital patients and in the outpatient clinic.

The Department also has local training programs in other state institutions. In addition, a 10-week postgraduate course for senior psychiatrists is now being offered at the Psychiatric Institute in New York City.

SUICIDE

A community center to treat suicidal persons has been set up at the Los Angeles General Hospital, with a grant of \$377,000 from NIMH. This will be a five-year research project, staffed by psychiatrists, psychologists and social workers; its aim is to gain more scientific information on suicide. Community agencies are making referrals of would-be suicides to the center, and the center is using public and private treatment facilities to handle patients.

Edwin S. Shneidman, Ph.D., University of Southern California, and Norman L. Farberow, Ph.D., Veterans Administration, the principal investigators, who have done previous research on the subject, have collected data on all suicides or attempted suicides in the country during the last 10 years. According to NIMH, the center "is recognized as the scene of the most comprehensive research on suicide both here and abroad."

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A report on suicide, titled "Smashup" appeared in *Newsweek*, November 2 issue. The article gave statistics similar to those which were published, in the first article on the subject by Dr. Joseph Hirsh, in the October issue of *Mental Hygiene*. Part II of Dr. Hirsh's four-part series appears in this issue. The *Newsweek* article included information obtained from the Los Angeles suicide prevention center (see above).

HALF-WAY HOUSES

To help convalescing mental patients of the Gulfport, Miss., Veterans Administration hospital adjust to normal community life, the hospital has arranged for their stay in two "half-way houses" in a quiet residential section of the city. These are operated by private owners, carefully chosen by social workers.

The experiment was begun in the summer of 1958 and so far, the hospital reports, has succeeded in its purpose.

Veterans living in the houses—36 are accommodated—return to the hospital during the day, Mondays through Fridays, to continue in therapeutic activities. Otherwise, they are on their own. They pay their own expenses from compensation and pension checks. They are selected for the experiment when they are deemed capable of attending to personal needs and handling money—ready to assume some responsibility.

Community acceptance, the VA reports, has helped the program to succeed. Many neighbors have asked VA officials how they can assist the ex-patients. All are free to participate in community recreational activities, and they may leave the city on visits to their friends and relatives.

DRAMA FOR PARENTS AND TEACHERS

Parent-teacher relationships have been dramatized in a one-act play, "I'll See You After School," written by Dr. Loyd W. Rowland, director of the Louisiana Association for Mental Health.

The play is about four mothers, each with a typical problem, and their separate conferences with the teacher who has their four children in her class. Through the conference, the teacher and the parent of each child gain a better understanding of the child's behavior.

On the basis of numerous presentations before the public, Dr. Rowland's play has been adapted to suit general audiences. It has been published, as a small, paper-bound booklet, by the Louisiana association and is available for production for a minimal sum—\$1 royalty for each presentation.

According to a note in the published text, the play was written "to emphasize the need to revive the waning art of communication between parent and teacher."

"Experience shows that discussion following the play will be quite lively. People see in the problems presented reflections of their very own." A discussion guide is included with the play.

"I'll See You After School" (at \$1 for single copies, \$5 for a 7-copy production kit) may be obtained from the Louisiana Association for Mental Health, 1528 Jackson Avenue, New Orleans 13, La.

PSYCHIATRIC AIDES CERTIFIED

A system of state certification for qualified psychiatric aides in California mental hospitals was established by law when Gov. Edmund Brown signed the bill titled SB 732 last summer.

The State Board of Licensed Vocational Nurse Examiners is now setting up standards and otherwise administering the new measure. The Board will begin issuing certificates after July 1 of this year. Certification is optional, but early applications are expected from a large majority of the nearly 10,000 psychiatric technicians employed by the Department of Mental Hygiene and graduated from its 300-hour, one year, in-service training program.

With the new law, California becomes the third state in this decade—along with

Arkansas and Michigan—to provide some form of legal assurance of the competency of its better prepared psychiatric aides, as a distinctive quasi-professional group.

Many groups have worked to realize this goal of certification. Co-sponsored by the state Psychiatric Technicians' Society and the State Employees Association, the legislation was supported by the California Department of Mental Hygiene, the California Association for Mental Health, and all major state organizations concerned with nursing.

It also reflects the objectives of aide groups in other parts of the country. Since 1944 NAMH has pioneered in advocating the development of nationally recognized standards for psychiatric aides and measures that would assure the professional ability of such mental hospital personnel.

PSYCHIATRIC RESIDENTS

The total number of psychiatric residents in training increased by 30% between August 1956 and August 1958, according to Fact Sheet 11, the latest report of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health.

This report also states that "the number of approved programs in which residents were enrolled increased from 215 to 245" over the same period. In 1956, there were 52 centers with no residents, despite the fact that the centers offered approved programs for psychiatric training. Two years later this number went down to 23 centers.

Residents in training were unevenly distributed geographically, according to the report, which shows that the New England and Mid-Atlantic states had almost twice as many residents per 100,000 population as did the rest of the country. Ten states had

no psychiatric residents in training and 22 states had none in training in their state hospitals.

Psychiatric residents with a foreign medical school degree increased 54%, or from 693 to 1,071, between 1956 and 1958, the report indicates. Residents with domestic degrees during this time increased by only 23%.

AWARD TO VOLUNTEER

Mrs. Jessie Hughes, of St. Louis, Mo., a volunteer at the St. Louis State Hospital, received the Lane Bryant Individual Award of \$1,000 last November for volunteer service to the community. She is the first individual associated with a mental hospital to receive this award; in 1951 it was given to a group—the Milwaukee County Association for Retarded Children.

Mrs. Hughes organized a corps of lay volunteers to work with mental patients at the 3,300 bed hospital. In her speech of acceptance, she said, "Over one-third of our patients never have a visitor, never receive a letter, never get a gift. Quite often they have to learn from volunteers that friendliness exists in the world before they are accessible to therapy."

DR. STEVENSON CONTINUES AS EDITOR

Dr. George S. Stevenson, editor of MENTAL HYGIENE, retired as national and interna-

tional consultant of the National Association for Mental Health on December 1. He is, however, continuing the editorship of this journal until a new editor is appointed.

Dr. Stevenson began his association with the National Committee for Mental Hygiene (predecessor of NAMH), as a field consultant in 1926; he became medical director of that organization in 1939. When the committee merged with the National Mental Health Foundation and the Psychiatric Foundation in 1950 to form NAMH, his position became that of advisor on the planning and organization of mental health services here and abroad.

He is presently psychiatric consultant to the U. S. Public Health Service and the Veterans Administration, treasurer of the World Federation for Mental Health, and associated with a number of other social service agencies and professional organizations.

CORRECTION

An error appeared in one of the references listed for the article, "Healthy personality and self-disclosure," by Sidney H. Jourard, Ph.D., published in the October issue of *Mental Hygiene*. The book was incorrectly listed as: "Jourard, S. H. *Healthy Personality: An Approach Through the Study of Healthy Personality*, New York, Harper and Brothers, 1958." The correct reference should be: "*Personal Adjustment: An Approach Through the Study of Healthy Personality*, New York, Macmillan, 1958."

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Notes and Comments

Aggressive behavior in relation to open wards in a mental hospital

The subject of open wards in mental hospitals has been one of renewed interest during the last few years^{1, 2, 3} and there are at least four mental hospitals in Britain which claim to have opened all of their wards. However, many medical superintendents, while approving of open doors in principle, and having progressively unlocked most of their wards, do not feel they can carry this to its logical conclusion. The advocates of the complete application of this policy claim that the unlocking of wards eliminates or reduces both the amount of aggressive behavior and the desire to escape, but their colleagues have not as yet been fully convinced by all of the arguments.

A report of the Commissioners of the Board of Control, commenting on changes in the administration of mental hospitals suggests that the most important changes

have been manifested chiefly in three directions: firstly, in the greater amount of liberty accorded to patients; secondly, in the increased attention that is devoted to their industrial occupation; thirdly, in the more liberal arrangements that are made for their comfort. In discussing the open-door

Dr. Folkard, a mental health research fund fellow at Netherne Hospital, Coulsdon, Surrey, England, presented this paper at a meeting of the Surrey Inter-Hospital Psychiatric Association in February 1957.

¹ Mandelbrote, B., "An Experiment in the Rapid Conversion of A Closed Mental Hospital into an Open-Door Hospital," *Mental Hygiene*, 42(1958), 3-16.

² Bell, G. M., "A Mental Hospital With Open Doors," *International Journal of Social Psychiatry*, 1(1955), 42-48.

³ Stern, E. S., "Operation Sesame," *Lancet*, 1(1957), 577-578.

system, the report states . . . "It appeared that the disuse of locked doors had an influence on some of the patients in diminishing the desire to escape. It is indeed, a thing of common experience that the mere feeling of being locked in is sufficient to awaken a desire to escape. . . . In determining the desirability of any kind of restrictive discipline and supervision, it has to be considered, among other things, whether the irritation which it occasions may not render the danger of accidents from violent conduct greater than it would be if such discipline were not enforced. . . . The superintendent who really takes most precautions against violence is not the man who applies the most complete restrictions upon liberty, but he who weighs the general result of different modes of treatment, and selects that which proves in practice most successful in decreasing the number of violent acts."

These observations were made by the Commissioners for Scotland⁴ in 1881, and are a clear indication that concern about the problem is by no means of recent origin, and the recognition of a close connection between restrictions and violence goes back to a much earlier period. In fact, the opening of mental hospital doors can be regarded as a logical extension of a policy which has characterized a great deal of the history and development of such hospitals. This was initiated by Pinel and Tuke when they removed chains from mental patients towards the close of the 18th century, and continued by Conolly and Gardiner Hill in

their attempt to institute a system of "non-restraint" with the complete abolition of mechanical restraints. Each stage in the development of this policy has stimulated a controversy regarding the extent to which mental patients should be allowed to have liberty of movement, both in terms of individual welfare, and in the interest of protecting the community.

UNLOCKING A FEMALE DISTURBED WARD

The following account describes the changes which occurred in a disturbed ward with the opening of its doors, particularly the effects which this had upon the incidence of aggressive behavior.

The patients on the female disturbed ward at Netherne Hospital were selected in the early part of 1955 as the subjects for a social investigation into the causes and treatment of aggressive behavior.⁵ At this time the ward was a locked one, as this was considered a necessary measure for the protection both of the hospital and the general community. At the time of the follow-up study in 1956, however, within the context of changing views and policy regarding the care and management of these patients, it was felt by members of the hospital staff that the risk or danger had been overestimated, and that the locked door in itself contributed to some of the difficulties and problems in looking after the patients. Most of the fifty patients had initially been sent to the ward because of aggressive or anti-social behavior, but it was felt that the restriction imposed by being locked in was for many of them a frustrating experience, and probably contributed to the maintenance of their aggressive behavior.

From the beginning of 1955 the ward had been the scene of considerable social and administrative changes, the sum effect of which had appeared to reduce the frustra-

⁴ Tuke, D. H., *Chapters in the History of the Insane*. London, Kegan Paul, Trench & Co., 1882, 374-386.

⁵ Folkard, M. S., "A Sociological Contribution to the Understanding of Aggression and Its Treatment in a Mental Hospital," London, Ph.D. thesis, to be published.

tions and aggressive tensions among many of the patients. In particular, attempts had been made to find more work or occupation for the patients within the hospital, and wherever possible outside the ward. The result of this was that by July 1956, 34 of the 50 patients were employed off the ward, either in the occupational therapy department, in the hospital kitchen, in other wards, or in the gardens. The remainder of the patients performed some kind of ward work, with the exception of three patients who were more or less unoccupied.

In addition to this, efforts were made to increase the number of patients who were given parole: in December 1954, 16 patients had either full or accompanied parole; in December 1955, 25 patients, and by July 1956, 36 patients. By this time it would seem as though the locked ward had lost a good deal of its significance for a majority of the patients. It no longer symbolized in quite the same way their enforced detention within the ward, for most of them could go out for a walk by themselves at any time merely by asking the nurse to open the door. As there is no wall or fence surrounding the hospital, which also has a public road running across the middle of the estate, there is no effective way of limiting the distance which patients walk when they go out on parole. This policy of giving the patients progressively more freedom, and of providing them with a full program of occupational and recreational activities, was conceived in part as preparing the way for the greater freedom which would accompany the opening of the door.

It was necessary as well to prepare the nurses for the opening of the door, for they had all been taught and led to expect that it was necessary to keep patients locked up, and one of their main functions in the past had been to prevent patients from escaping. The custodial attitudes of the nurses had

to be modified, and some measures taken to reassure them about the possible consequences of the action that was about to be taken, particularly by relieving them of responsibility for absconders.

The problem was extensively discussed at the ward meetings with the nurses over a considerable period of time, and they were encouraged to express their views, and to make suggestions and criticisms. It was felt that it might be necessary to transfer to other wards several patients who were active absconders, but when the time came not even these patients were removed from the ward, and no patient was moved because of her aggressive behavior, or for any other reason. By the time the door was opened most of the nurses had become convinced of the desirability of this action, although a few of them were still somewhat anxious and apprehensive about it.

As a final preparation, the ward doctor held a ward meeting of all the patients a few days prior to the door being opened, explained to them what was going to happen, said that it was looked upon as an experiment, and appealed for their co-operation to ensure that it would be successful.

One of the purposes of the social research was to evaluate the effect of this procedure, particularly upon the incidence of aggressive behavior.

The data presented here relate to 45 patients, of whom 31 were schizophrenics, five were epileptics, four were psychopaths, two were manic-depressives, and three were mental defectives. The average age was 39.5 years, with a range of 19 to 65 years; and the average length of stay in the hospital was 8.4 years, with a range of one to 23 years.

The investigation extended over a period of 20 weeks, from April 29 to September 15, 1956, and the ward was opened half way through, at the end of 10 weeks, so that

data are available for comparable time periods before and after the opening of the ward.

Systematic records were kept of all incidents which occurred; these were defined as "personal aggression" if directed at other individuals either in the form of verbal or physical attack, and as "impersonal aggression" if directed at property either in the form of breaking, banging, or knocking things over. The technique of data-collection is discussed elsewhere.⁶

RESULTS

In the "open" period compared with the "locked" period there was a reduction in the number of incidents from 249 to 193, and at the same time a reduction in the number of occasions when action was taken by the staff (sedation, electro-convulsive therapy, and putting the patient to bed) from 57 to 46. This overall comparison, however, obscures certain important differences in the weekly figures, as shown in the following table, for there had been a reduction in the number of incidents over the 10-week period when the ward was still

locked, from 144 during the first five weeks to 105 during the second five weeks.

This trend continued during the first five weeks after the door had been opened, when there was a further reduction to 76 incidents, although this included a slight increase from the third to the fourth week, when one of the two ward nursing sisters left the ward. During the second half of the open-door period, however, there was an increase in the number of incidents compared with the first half, from 76 to 117. This increase occurred during the last two weeks of the period, when the second nursing sister was on holiday, so that at this time both of the regular ward sisters were absent from the ward. The greater disturbance on the ward is further reflected in a considerable increase in measures used by the staff during these two weeks, when 32 positive measures were taken, compared with only one during the previous two weeks. It would seem that this increase in the number of incidents was directly related to changes in the staff situation, and that the increase in the amount of "treatment" reflected the anxieties of the new nurses who were in charge of the ward when confronted with an increase in ward disturbance.

⁶ Folkard, M. S., *ibid.*

Aggressive incidents on a female disturbed ward

	WARD DOOR LOCKED			WARD DOOR OPEN		
	Period I	Period II	Total I & II	Period III	Period IV	Total III & IV
Number of incidents	144	105	249	76	117	193
Action taken						
Put to bed	15	10	25	5	21	26
Sedation	12	15	27	4	12	16
E.C.T.	3	2	5	0	4	4
Total	30	27	57	9	37	46

Note: Periods I, II, III and IV were consecutive time periods, each of five weeks' duration. The ward door was unlocked half-way through the investigation.

The evidence would seem to suggest that the unlocking of the door was, in fact, one factor in helping to reduce the amount of aggression on the ward, but that this by itself is not a complete solution to the problem. Even when the ward is open, other events, such as changes among the nurses on the ward, can produce an increase in the amount of disturbance, possibly greater than that which existed before the doors were unlocked.

Apart from the last two weeks, and the circumstances associated with them, the open door period was not accompanied by an increase in the use of "treatment," but by fewer incidents and less "treatment."

There was not an increase in the number of patients who absconded, for although the amount of supervision appeared to be about the same, there were only three patients who absconded during the open door period, compared with four patients during the 10 weeks before the ward was opened. None of these patients constituted a problem with regard to aggressive behavior.

IMPLICATIONS FOR HOSPITAL POLICY AND MANAGEMENT

Preconditions of the open-door system. There is fairly general agreement, even among those who operate the open-door hospitals, that all of the wards cannot be opened without any preparation or further action. The success of such a scheme depends in large part upon the implementation of a full program of occupational and recreational activities, and by an attempt to meet the varied needs of the patients as adequately as possible. It depends also upon having an adequate number of nurses on the ward who are in sympathy with the hospital policy, and who do not regard their role as being purely custodial. Where the scheme has been most successful it has consisted not in suddenly opening all of

the wards at the same time, but in the progressive opening of one ward at a time, so that patients and staff gradually came to accept the idea, and even to suggest and initiate the next step themselves.

Some practical difficulties. The development of these pre-conditions in many hospitals is limited at present by the problem of overcrowding, the shortage of nurses, and inadequate resources of various kinds. There is considerable difficulty in controlling the aggressive psychopathic type of patient under a permissive regime, and some hospitals seem to possess more of these than do other hospitals. Perhaps the open-door hospital can only function as such while there exist other hospitals with locked wards to which these patients can be sent.

The success of the open-door hospital depends in large measure also on the extent to which it is accepted by the general public, and this acceptance will exist only so far as they do not perceive it as a threat to their safety. When some act of violence is committed as a result of a patient absconding, there are usually demands for the introduction of stronger security measures.

Staff attitudes and expectations. The attitudes and expectations of the staff who look after the patients are of importance in understanding how aggressive behavior is dealt with, and in evaluating the effects of any social action that is taken. The behavior of the staff may be based upon false assumptions of one kind or another, and these may lead to unrealistic expectations.

Firstly, there is the possibility of oversimplification; there may be an attempt to find a single cause to which there will be a single remedy. For instance, it may be suggested that aggression is the result of frustration due to locked doors, and that aggression will, therefore, disappear when the doors are opened. Such a type of explanation

may be applicable to many forms of physical illness, but hardly seems adequate when dealing with complex behavioral problems.

Oversimplification may also take the form of stereotyped attitudes. In the past there was a fairly widespread belief that all mental patients were potentially violent and dangerous, and should always be locked up. There have been considerable changes in attitudes towards the problem, and fewer people would now express such an extreme viewpoint. There is a tendency in some instances for the emergence of the opposite stereotype, that no mental patient is sufficiently dangerous ever to require locking up.

This problem seems related to that of the possibility of confusing actual conditions with ideal conditions, so that under a strong motivation to improve a situation and produce results, certain problems may be discussed as though the goal had already been accomplished. A doctor who is personally involved in the success of a therapeutic program may, through selective perception, have an impression of greater progress than has in fact occurred.

This situation may be in part brought about by his confronting the ward staff with unrealistic expectations and demands, and they, by a similar process of involvement, or from other motives, will produce the appearance of success. If there is strong pressure against the use of seclusion, this measure may be used in certain difficult situations without the fact being officially recorded. Likewise, the open door may be occasionally locked, or perhaps only opened during certain periods of the day when the most difficult patients are employed in other departments off the ward. The patients may

be restrained by closer supervision and stricter discipline, and their freedom of movement may be restricted by not granting them parole; the sight of an open door through which he is not allowed to pass may be more frustrating for a patient than a locked one.

This last point raises the problem of trying to understand the meaning and significance of the locked door from the patients' point of view. In a survey of the reactions of 35 women patients in an American mental hospital⁷ some three weeks after their ward had been opened, 20 subjects said that they had not noticed any change. When asked specifically whether or not they liked the open ward, 22 of the patients replied that they liked the change, nine of them said they preferred a locked ward, and four expressed indifference. No patient mentioned any connection between the change and her chances of going home. The author tentatively concluded that many mental patients may be expected to react negatively or apathetically to the opening of their ward, and that, in general, chronic psychotic patients tend to view freedom with considerable difference from the way well people view it.

These observations suggest the need for more systematic research which is geared to the problem of establishing facts and testing hypotheses rather than to proving of creeds.

The significance of the locked door as a cause of aggression and as a mechanism of control. There is evidence to show that many forms of restraint and restriction, although initially designed to prevent or limit the effects of aggressive behavior, to some degree help to cause the very behavior which they were intended to prevent. A locked door, in so far as it limits the freedom of movement of the patients, may be a source of frustration, and contribute to the development of aggressive

⁷ Scott, D., "Chronic Mental Patients' Reaction to Opening Their Ward," *American Journal of Psychiatry*, 113(1956), 336.

tensions. This may be mitigated for many patients, however, by the granting of parole. Moreover, some patients tend to view the locked door not as a form of restraint, but as a means of keeping their persecutors out of the ward, and therefore as a form of defense and protection.

The research at Netherne Hospital⁸ has shown that aggression may arise from many causes, including various forms of social interaction with other patients and with members of the staff. Such sources of aggression are not likely to be eliminated by the opening of doors.

There are also various mechanisms of control of which the locked door is only one. These include the use of strict discipline, the withholding of parole, and the withdrawal of "privileges," and we cannot say which of these constitutes the most frustrating experience for patients.

It is socially necessary that members of any society or community, including those of a mental hospital, should show a minimum conformity to the norms of that community, and some procedures must be employed to ensure adequate regulation of behavior. The problem arises whether deviant behavior can be controlled by positive measures, such as by more adequate

fulfillment of individual needs, the removal of sources of frustration and restraint, the giving of rewards for conforming behavior, or by attempting to develop mechanisms of self-control. The development of such measures in the past has been accompanied by a considerable degree of success, but it has not completely solved the problem of the social deviant who disregards rules and regulations, and who by aggressive behavior inflicts injury upon other members of the community.

Mental hospitals have made considerable progress in their development from custodial to therapeutic institutions, but there is the need for further development of hospital policy, aided by objective research, which will meet both the public's demand for protection, and the right of the patient to that amount of freedom which is most conducive to his recovery and welfare.

ACKNOWLEDGMENTS

My thanks are due to Dr. R. K. Freudenberg, physician superintendent of Netherne Hospital, for his criticism and advice, and to the nursing staff, without whose co-operation and assistance this work could not have been undertaken.

⁸ Folkard, M. S., *op. cit.*

JOHN V. ALBRIGHT

Religion in a psychiatric setting

A great deal has been said in the last generation about the relationship of religion and psychiatry. We are generally agreed now that there can be cooperation between these fields or, rather, cooperation within the field of human relations where the psychiatrist and minister meet. We have passed that stage when the majority of ministers felt that the psychiatrist had to be an atheist and when the psychiatrist looked at religion as a collective neurosis.

For 30 years now the chaplain has been on the mental hospital scene. His acceptance there has done a great deal toward bringing an appreciation of the religious into the psychiatric community and an understanding of the values of psychiatry into the ex-

perience of the church. However, our tendency is to compliment ourselves on our ability to tolerate each other to the neglect of looking below the surface to examine our relationship for the purpose of analyzing our latent hostile feelings in order to find those areas where we might increase our team efforts for the good of the patient.

To the end that this philosophical and functional understanding might ultimately be achieved among the various disciplines of a psychiatric community, this paper will attempt to present one understanding of the place of religion in a psychiatric community. To do this, we shall first sketch briefly the background for a religious ministry in the Protestant Christian faith. Then we shall try to differentiate between the "religious" and the "psychiatric" and finally discuss the role of the chaplain.

Mr. Albright is the chaplain at Arkansas State Hospital, Little Rock.

THE CLINICAL TRAINING MOVEMENT

Christian faith in time runs concurrent with our calendar, getting its impetus historically from Jesus, a man of Palestine who was known as a healer and teacher and prophet. This man became known as the Christ and thus became the theological impetus of the church. All this you know, but it is mentioned to bring to you the fact that in the beginning there was a healing ministry, that among other things Jesus was known as a healer.

Now there came times in the history of the church when it opposed the healing arts, especially those studies that would bring about knowledge of the human being and therefore the ability to heal him better. Probably at no point in medicine did the church thwart the forward movement as much as in the area of mental illness. The church could understand physical illness, but mental illness was so closely tied to the provinces of ethics that the church fought against conceding that this area might benefit from any study other than that of theology. We shall not say that the church did nothing in the area of mental health until the late 1920's and early 30's, but the development of understanding of the problems of mental health and mental illness really came to focus in the Protestant churches around 1930 in the person of Anton Boisen.

Dr. Boisen had his first psychotic break and was placed in an institution shortly after World War I. He wrestled with the problem of mental illness in the hospital and won the first fall. On his discharge he felt that his experience in the hospital might have been less painful and his recovery obtained sooner if he had had mature religious guidance. Being an ordained minister himself, he decided to see what he could

do about the matter. He took graduate study in the field of psychology and with the encouragement of Dr. Richard C. Cabot, became the first full-time chaplain on a hospital staff. From that day to this he has been the leader in the field of pastoral care to the mentally ill. He is now retired, but still serves as consultant to the chaplain's department of Elgin State Hospital in Illinois.

This concern for pastoral care has been called the clinical training movement and is now being incorporated in the curriculum of many of our seminaries. There are now a number of training and accrediting groups in this field, but the primary ones have begun a cross-accrediting agency known as the National Conference for Clinical Pastoral Education. Training groups belonging to this agency are the Council for Clinical Training, founded by Boisen, the Institute for Pastoral Care founded by his friend Dr. Cabot, the Lutheran Advisory Board and the Southern Baptist Association for Clinical Pastoral Education.

WHAT IS RELIGIOUS AND WHAT IS PSYCHIATRIC?

It is not possible to make a complete dichotomy between what is religious as opposed to what is psychiatric. However, the matter is worthy of consideration. Let us get into this discussion from a negative aspect by pointing out some of the referrals the chaplain is likely to receive which indicate that the idea other people have of what is religious and what is psychiatric is at variance with the purpose of a chaplain's department.

The referral made on the basis of getting the patient out of one's hair is not uncommon. Frequently there is the patient who demands to be allowed to make a telephone call. The demand is refused. He demands to see the doctor. The doctor has already seen him or is not available. He demands

to see a nurse, and the nurse is occupied giving shots. In each of these situations the aide does not hesitate to say no to the patient, but perhaps he does hesitate to tell the patient why he is saying no—that is, that the patient is being too demanding. The patient then asks to see the chaplain, and the chaplain is automatically called. An overdemanding patient is no more a religious problem than a psychiatric problem.

Frequently a referral comes to the chaplain's office with a comment from the person referring that "I think the patient needs to ask for forgiveness." The patient may well need religious guidance, but at this point the only person accepting religious guidance is the person making the referral and he is accepting it only for another. The chaplain's effort in this type of referral is usually wasted.

At times the chaplain is called in to reinforce the limits someone else on the staff has set—almost as if it became a matter of religion when help was needed to "bring a patient into line." This is not fair to the chaplain.

It is not necessarily a matter of religious concern (although this kind of referral is frequently accepted) when a patient is obsessed with the idea that he has the ability to heal or states that he is God or the Christ or that he has a world mission. This is the psychiatric problem of a deep-rooted delusional system and does not differ qualitatively or quantitatively from other delusional systems or obsessional ideas. When accepting this kind of referral, the chaplain and the psychiatrist should be agreed that the best that can be expected is that the

religious ideation will be dealt with in such a way that its psychiatric meaning can be explored—the religious worker, like any other worker on the team, will not be able to argue the patient out of his delusion.

At this point this paper is squarely opposed to the idea expressed by Adolph Meyer when he said: "Here we find two main routes: the interest of the minister is largely one of guidance from above; ours is largely attention to guidance from the roots, but by no means exclusively so."¹

We believe as Dr. Wayne Oates² said with the title of his book that there are religious dimensions of personality, but this does not call for a double approach because of a division into the spiritual person, that guided "from above," and the natural person, that guided from the "roots." The psychiatrist, the social worker, the psychologist, the other disciplines and the chaplain see the same person and we see him in similar circumstances.

What, then, are some of the areas of life in which religious counseling is appropriate?

When one deals with the religious needs of the patient, his primary concerns are freedom in the light of that which is determined, value in the midst of any disvalue, and fellowship in the experience of one who is out of relationship to others either because he has constructed his own world or has been rejected in the world of people. Each one of these—freedom, value and fellowship—needs a chapter written about it, but let us state that there is an element of determinism and an element of freedom in every man. The element of determinism is expressed in his instincts, drives, capacities, abilities and station or place in life. These might constitute, percentage-wise, 99% of his present circumstance, but if there is 1% of freedom within the individual, then there is something for us to work with.

¹ Lief, Alfred (ed.), *The Commonsense Psychiatry of Dr. Adolph Meyer*. New York, McGraw-Hill Book Co., 1958, 524.

² Oates, Wayne E., *The Religious Dimensions of Personality*. New York, Association Press, 1957.

Values are crucial, for part of what a patient brings into the hospital is his inability to cope with that which seeks to destroy the things he holds valuable. Our purpose is not to try to convince him that his values are not threatened but to work with his values that he might yet achieve, as Viktor Frankl states in his book *The Doctor and the Soul*: "... the greatness of a life can be measured by the greatness of a moment; the height of a mountain range is not given by the height of some valley, but by the tallest peak. In life, too, the peaks decide the meaningfulness of the life, and a single moment can retroactively flood an entire life with meaning."³

That is one of the bases of a religious philosophy of counseling—that we counsel not to see how sick the patient is or to delve too deeply into the soreness in the personality. But having some idea of where these areas of soreness are, we can help the patient to see the values that have not yet been used and the values which, only partially destroyed, can be preserved.

Relatedness is one of the primary difficulties in mental illness. The mental patient's inability to communicate with people to relate to them and to feel accepted by them is a basic problem. Religion promises him a relatedness to a minister to whom he can communicate and who will accept him with a promise that, though he himself can help only to a limited extent, he is sent by One who has greater understanding and who is more willing to relate, to accept and to communicate.

The implications of these principles can best be brought out if we spend some time discussing religion in a psychiatric setting.

RELIGION IN A PSYCHIATRIC COMMUNITY—THE CHAPLAIN

As we speak more specifically about the role of religion in the hospital, primarily the role

of the chaplain, we find it easily divided into three sections: the chaplain as a minister, the chaplain as a therapist and the chaplain as a member of the therapeutic team.

As a minister the chaplain does those things that any minister does but with a keen eye to their psychiatric implications. Let us list some of the activities of the minister.

- Chapel services: These are not organized for the purpose of arousing the emotions of the patient, but to bring him into a relationship which will help him deal constructively with the problems he has to face. Responsive reading and hymn singing help him to relate to other people. The bulletin and the hymn book give him a grip on something real, and references to them are reality orienting. The reading of the Bible brings him into contact with the best that has been said about God's relationship to people.

- Hymn singing: A minister might have a song service on a ward. A certain ward would be selected because of the patients' need, and not simply to satisfy the minister's desire for a song service. This means he might go to the geriatric ward where sermon exhortations would be largely lost on the patients but where the singing of the old songs of the church would give them the rhythmic stimulation of music and probably bring to the surface some of the more positive experiences these elderly people had in an earlier period of life. The minister should be careful to pay attention to the types of songs that are requested to see where the concerns of these people lie, so that in person-to-person conversation with them he can deal with their problem areas and speak

³ Frankl, Viktor E., *The Doctor and the Soul*. New York, Alfred A. Knopf, 1955, 49.

Stanton and Schwartz, *The Mental Hospital*,⁶ when they state: "The most striking finding was that pathologically excited patients were quite regularly the subjects of secret, affectively important staff disagreement; and, equally regularly, their excitement terminated, usually abruptly, when the staff members were brought to discuss seriously their points of disagreement with each other."

The chaplain is a member of the team in terms of referral. In our relationships with patients there are times when they ask us to deal with material which can best be dealt with by another member of the therapeutic team. The chaplain ought to be aware of what the other disciplines are doing so that he can intelligently refer patients to the proper person when referral is indicated.

⁶ Stanton, Alfred H. and Morris S. Schwartz, *The Mental Hospital*. New York, Basic Books, 1954, 345.

SUMMARY

It is the thesis of this paper that while the psychiatric worker and the religious worker have agreed that they have many areas of common concern, each often finds himself working without a clear conception of what the other is trying to do. Therefore, there is given a brief description of how the religious worker came to be found in the psychiatric setting, with a discussion of some ways that he ought not to be used and some ways in which he could be useful to the therapeutic program and remain first and foremost a religious worker.

We have not hoped that our statement would be the final word in this matter, but rather that we might stimulate others to consider this too little understood area of human relationships—the relation between religion and psychiatry.

PETER E. SIFNEOS, M.D.

A concept of “emotional crisis”

From January 1953 to June 1955, 108 individuals were seen by the author of this paper at the Human Relations Service of Wellesley, Mass., a mental health agency in an upper-middle class Boston suburb. Although this may be a very small percentage of the millions of people who at times of stress seek professional help, it may be large enough to be typical of the emotional conflicts and reactions to hazardous situations of ordinary human beings in a state of emotional crisis.

GENERAL FINDINGS

Of the 108 that were seen, 84 were women and 24 were men, a ratio of 4 to 1. Ninety-five were married; 13 were not (10 were single, 2 divorced, 1 widowed). Most of them were young. Seventy percent ranged in age from 20 to 50 years and 20% were in their teens. Of the remaining six, four were in their 50s and the other two were 61

and 67 years old. Protestants outnumbered Catholics by 3 to 1. Twenty-five belonged to family units in which at least two other members of the family were interviewed.

They were referred to the agency from various sources. School teachers referred 24, private physicians 16, the nursing school of a nearby hospital referred 8, clergymen 6, a local family agency 2; 52 were self-referred.

From the many reasons that were given for coming to a mental health agency and seeking help, the presenting complaint usually did not reflect the true hazards faced at the time. It was, if anything, some sort of excuse or justification for their visit.

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Some even mentioned that they had come only to please the referring physician or teacher; yet it was obvious that they had problems. Here are some of these complaints: "The school principal says my daughter should get better grades." "My nephew is insane. Would it help if he visited this agency?" "My son cries and is unwilling to go to school." "My husband cannot get along with my youngest boy." "My clergyman thinks I should consult you about my daughter's rebellious behavior."

Anxiety feelings about some of these complaints were usually minimized initially, but there soon followed the admission that such feelings existed in addition to "fear and nervousness" and that their attempts to deal with them had been unsuccessful. Some visitors on the other hand admitted right away anxieties about the behavior of another member of their family: "I am upset about my four-year-old boy's thumb-sucking." "I fear that my son is ready to run away from home. What shall I do?"

Other individuals openly worried about themselves. "I feel that the top of my head is going to fly off." "I wonder why my hands always shake when I go out on a date." "I feel at times that life is not worthwhile." "I am worried about the failures of my three previous marriages. I am getting married for the fourth time in another week."

The environmental, hazardous situations that gave rise to painful emotions of fear and anxiety in these individuals were the loss of a member of the family by separation, illness or death; the disturbed behavior (excessively passive or aggressive) of a member of the family, usually a child; a disabling physical or mental illness of another member of the family; a new arrival in the family orbit (such as a birth, the return of

a son after service in the armed forces); a change in civil status (marriage); moving into a new community; a change in roles forced upon an individual by changes affecting another member of the family; a new job, retirement or unemployment; entering college, professional school, or even kindergarten; and isolation of the family from the community.

There were also anxieties associated with changes in the individual himself, such as physical illness, incapacitating injury, puberty, climacterium, pregnancy or the onset of mental illness.

It was usually apparent that within the recent past some event had taken place which acted as a precipitating factor and which seemed to bring the anxiety into the open from its somewhat dormant state, thus motivating the individual to visit the mental health agency. For example, a talk with a general practitioner acted as the precipitating factor in more than 50 people (although only 16 were directly referred by their doctor). Interviews with a teacher were precipitating factors in many cases. Visits to clergymen, lawyers, nurses, job supervisors, or even a talk with a policeman or a friend turned out to be precipitating factors. Sometimes the individual's interview at the mental health agency also acted as a precipitating factor for getting another member of the family to visit the agency. This happened in 17 cases. A visit to a private psychiatrist or social worker, impending examinations at school, physical examinations, fights with a relative, new jobs, admission to or discharge from a hospital, meetings of the League of Women Voters or Parent-Teachers meetings, engagements, trips to Europe, the possibility of a child's expulsion from school—all acted as precipitating factors.

Anxiety seemed to be the main motivating force and the hope of relief from anxiety

ety the reason why these individuals came to the Human Relations Service. The defense mechanisms used in the attempt to handle anxiety varied according to the personality of the individuals. The need to call on additional defense mechanisms became apparent when the anxiety could not be properly handled and the awareness of this painful emotion became intensified. They were then in a state of emotional crisis.

The following cases illustrate the hazardous situations, anxieties, emotional crises and attempts to cope with them.

CASE #1

A 35-year-old man came to the Human Relations Service because his wife had decided to see a psychiatrist following a talk with her minister. The wife, an emotionally disturbed woman, had no friends, was suspicious of people and drank excessively. She was two years his senior. Her mother, an alcoholic, had burned to death while drunk. Her father had left the family when she was two years old. Her brother was in prison for theft.

This man had met his wife at a bar where she worked as a waitress, had been attracted to her and excited by the idea of "saving her" from her "terrible life." After their marriage despite his wife's "peculiarities," he was supportive and never antagonized her. He never complained about her inability to discipline the children, nor about the sloppiness of their home. He was understanding of her temper tantrums even at times when he had to sit up all night listening to a tirade of complaints. In the evenings after he returned from work he cooked a meal and then fed, bathed and put their two children to bed. He derived much satisfaction from being his wife's "savior," "the main pillar of support of the

whole family." The news that his wife planned to see a psychiatrist made him realize that his family life could be altered, and he felt annoyed at the minister who recommended psychotherapy to her.

It was apparent that living with an emotionally disturbed woman for 10 years was not the problem for this man. The hazardous situation that threatened him was the possibility that his wife would get well. This became clear in the first interview. He decided he did not want to return for a second visit.

The more his wife improved, the more upset and tense he became. On one occasion when she told him that her psychiatrist had become her "main support," he became angry. He realized that he was unable to cope with the situation but did not know what to do. When his attempts to persuade his wife to stop seeing the psychiatrist failed, he became panicky. Having been unsuccessful in seeing the psychiatrist himself, he became depressed and stopped working, but returned to the agency for help.

Over a period of three months he was seen six times. An attempt was made to help him reverse his regressive behavior. By the end of that time his depression had improved and he was able to accept, as a *fait accompli*, his wife's new role as a mother. He was also able to canalize his abilities in other directions, and to return to work. He joined a political club and quickly became actively engaged in all its activities. Two months later he was elected vice-president and was able to get both financial support and many new members. He felt better and proudly talked of his being the "pillar of support" for his club.

It seems that this man developed anxiety and became angry at the time of a hazardous environmental situation. Unable to deal with it, he grew more anxious. He was in a state of emotional crisis. Still

not able to cope with it, he became depressed. The failure to see his wife's psychiatrist acted as a precipitating factor that brought him back to the agency.

His attempts to cope with all this by regressing failed. The introjection of his hostile feelings, being a maladaptive reaction, gave rise to the symptoms of depression, during which time he described himself as being discouraged, feeling tired and guilty. These reactions (regression and introjection) as well as the resulting symptom of depression, isolated this man from the outside world—he stayed at home and did not work. His temporary incapacitation, and the use of the agency for his support, helped him mobilize all his resources to face this emotionally critical situation. It is of interest that such a seemingly pathological reaction from the clinical point of view enabled an individual to overcome his difficulties and helped him return rapidly to a state of emotional equilibrium.

CASE #2

A 23-year-old law student developed tuberculosis and had to give up law school for a period of two years. After his discharge from the hospital he decided to take a trip to Europe by himself before returning to school. His mother objected to this because she worried about his health. She was overprotective, warned him not to get caught in drafts, and wanted him to stay in bed.

He became upset by his mother's overprotectiveness. When she failed in her attempts to persuade him not to go to Europe, she tried to plan the whole trip for him. He reacted to this by being bewildered at first and anxious, then angry at the whole situation. Two years of being dependent lying in bed had been enough for him; he now wanted to be on his own. He talked to a good friend of his mother's

who suggested the Human Relations Service.

The night before coming for his first visit he quarreled with his mother about his girl friend, having mentioned to her the possibility of marriage. His mother became upset, started to cry, and said that no woman was going to "take her son away from her after two years of separation." Furious, he thought of packing and leaving home, but changed his mind. The next morning he came for help.

Talking about his difficulties he could quickly see that his overactivity was a reaction to his mother's overprotectiveness. Yet he also could see how he did wish to depend on her. He went back to talk again with his mother. He returned the next week saying that they had reached a compromise. He was to postpone his marriage to his girl for some time. He was to go to Europe, spend a month in a small town, which is what he wanted to do, and another month following his mother's plan. He said he understood better his mother's need to be overprotective after a long separation. He also felt that there was no need on his part to deny with such vehemence his longstanding dependence on his mother. A *modus vivendi* was found.

This case shows how a well-integrated person felt threatened and used flight as a reaction against anxiety arising from a dependent relationship. In one interview he was able to gain enough insight, reach a satisfactory compromise and keep intact his good relationship with his mother.

CASE #3

A 52-year-old married woman came to the Human Relations Service complaining of being "at the end of her rope." She said that throughout 20 years of marriage her husband had been fearful of everyone, locking the doors in every room of their

house, always looking under the beds at night, feeling at times people were against him, and being in a state of turmoil. She also described her husband's toilet habits. He always kept stools in three different toilets, flushing them only twice a week. She and their two daughters had to share the fourth bathroom. Ten years previously her husband had had a "nervous breakdown," at which time he had stopped working. She had taken good care of him by herself, and he recovered soon after.

All the years of what appeared to have been a stressful marriage she had lived happily, denying her husband's difficulties, rationalizing his queer habits, and saying to herself "all people have peculiarities."

Her husband was successful financially. He used his house as an office. He invested wisely and amassed a large fortune for himself and his family. His wife was able to point to his financial wisdom by saying that "he was a genius." She seemed to be unaware of the extremes.

On the occasion of her daughter's graduation from high school, she decided that the whole family should take a cruise. Her husband was reluctant at first, but after much pressure from his wife he finally gave in. Difficulties, however, developed as soon as they embarked when he realized that they had to share a toilet with the people in the next cabin. Her husband immediately became suspicious. His peculiar behavior made him the center of attention and ridicule of the other passengers. On one occasion he was the object of much ridicule and laughter when, fearing that his clothes had become contaminated, ran nude from the ship's swimming pool to his cabin. His wife at that time overheard a passenger speak about "that crazy man" and became upset. Later on, when one of her daughters had an argument with her

father and said, "Mother, I cannot see how you were able to live with a mad man for 20 years," she became anxious.

What gave rise to difficulties in this woman was the realization that her husband was sick. She immediately arranged for the whole family's return home, but the thought that her husband was sick lingered on and her anxiety continued. She decided to nurse her husband as she had done 10 years previously, but his reaction was different this time. He angrily accused her of arranging the trip and of plotting to expose him to a hostile world, and of putting him at the mercy of evil people who were against him. For the first time in their marriage he turned against his wife. On one occasion he grabbed her by the neck and tried to choke her. It was then that she decided to visit her minister and seek help. This visit precipitated her coming to the mental health agency.

"If I could stop thinking about my husband as being angry at me, everything would be all right. But I cannot, and I am thinking of divorce for the first time," she said. As long as her husband expressed his anger against others she was not threatened, but when he directed his hostility at her she was unable to tolerate it and immediately became anxious and tense.

An attempt was made to convince her that her husband still needed her help. It was pointed out to her that sick people at times express their anger at the ones they love most, and that her husband's anger was a symptom of his illness. It was also mentioned that divorce or separation would mean abandoning a man in need. In the next two interviews she expressed her anger at her husband but also professed willingness to help him and to tell him that she would not leave him. He accepted her statements, reluctantly at first, but he soon relaxed and was willing to be taken care of.

In this case anxiety developed in this woman after a hazardous trip. It increased when her husband's hostility was turned against her and she was unable to deal with it, deny it or rationalize it. She was in a state of emotional crisis, and thinking of divorce as a solution to her problem. In the psychiatric interviews, ventilation of her hostility toward her husband and reinforcement of the belief that she was essential to him quickly mobilized her resources and helped her re-establish her emotional equilibrium. This in turn helped her husband to stabilize himself.

CASE #4

A husband and wife came to the Human Relations Service together. The wife was seen by the psychiatrist and the husband by a social worker. They had had a fight on their way to the agency. The wife talked about her husband angrily. Her speech was rapid and at times incoherent. She described her fear of her husband and suspicions of other people. She mentioned a "plot" against her life.

The wife, who was 29, was an only child. Her mother had died when she was six months old. Her father was still living. Following the birth of her first child she felt nervous. She said she was unable to cope with the responsibility of bringing up children. Trying hard to cope with her children's demands, she became more and more meticulous in her housework. She started compulsively to do the same thing over and over again. "I gave the appearance of a perfect housewife with a perfect household. Yet I could see things slipping."

Her fifth pregnancy was the "*coup de grace*," she said. "Cracks started to show but I still tried to keep up the front. I started to have fears about being sick and about dying." She thought of suicide. In-

terestingly enough, she still tried "to keep up the pretenses."

Following the delivery of her fifth child she developed an infection and returned home exhausted. She was unable to breast-feed her baby. It was then that she became suspicious of everyone, and finally after an argument with her husband she came to the agency to complain about him.

The husband talked about his wife's "mental illness." He was eager to give his side of their marital problems. He said his wife was an excellent housewife, but he was upset by her inability to take care of their children during the past few months.

The wife returned the next day more agitated, yet she refused to go to a mental hospital. Arrangements were made for her minister and her father-in-law—two people she trusted—to be present during her third visit. They both helped persuade her to enter the local mental hospital.

Her husband was seen supportively. He also had a long history of emotional difficulties. He alone took care of the children. He was visited at his home, where he was "in action" taking care of his children, who ranged in age from eight years to four months. He did a competent job and the children appeared happy. It was easy to motivate him to seek psychotherapy for his own emotional difficulties.

His wife was treated at the mental hospital for six months. She was discharged and continued psychotherapy with a doctor from the hospital. The agency kept in contact with this family for two years. There was no disturbed behavior of the two older children, who were in school. The wife, despite her serious emotional problems and character disorder, appeared relaxed and happy.

This case shows both a husband and a wife in crisis. One can observe how the wife's attempts to face the hazards of re-

peated pregnancies failed, and how by trying to keep up pretenses and using inadequate defenses, both for her adjustment to the outside world as well as to her own present emotional crisis, she progressively deteriorated until she required hospitalization.

CASE #5

A 35-year-old married school teacher, mother of an eight-year-old boy, came to the agency complaining of anxiety in connection with the visit of her mother-in-law. She was an intelligent, pleasant woman, a college graduate, who related well to the interviewer. She described her marriage as being happy, up to the time of her mother-in-law's visit from England. At first she made every effort to get along well with her, but when the visitor mentioned that she was planning to stay indefinitely the patient became anxious. Her anxiety increased when she was criticized about teaching school instead of staying at home. It was intensified when her husband's mother started to discipline her son. She tried to react to this by discussing the whole situation with her mother-in-law, but failed. Then she started to feel more inadequate. Her work at school suffered. She began to be afraid to walk alone in the streets, particularly at night, and developed nightmares.

The day prior to her visit to the agency she had had a fight with her husband because he refused to ask his mother to leave. She then decided to stop teaching school.

The prospect of having her mother-in-law living with her indefinitely generated anxiety. Unable to cope with it, she became preoccupied. She was in an emotional crisis. Still unable to deal with the situation, she developed phobias.

Her husband was also seen, and an attempt was made to explain to him the

problem faced by his wife. He seemed to be willing to cooperate.

The wife was seen on four occasions over a period of eight months. On the second visit she said that her mother-in-law was still staying with her, and that her husband had been unsuccessful in convincing her to go. She was encouraged to take matters in her own hands.

The second interview with the husband showed that his feelings for his mother had changed. He was angry with her because she was having an affair with a man her own age and was considering divorcing his father and marrying this man. This shocked him, but it was his wife who became determined to ask her mother-in-law to move out of his house. She finally succeeded.

When the patient was seen, two weeks later, she was feeling much better. The temporary interruption of her work at school had helped her concentrate on her son and on her housework; thus she had been able to cope with her mother-in-law's accusations. Her phobias had decreased.

When she was last seen, six months later, she had returned to school teaching and was symptom-free. Her mother-in-law, disappointed in her love affair, had returned to England. All was well with the patient.

In this case a well-functioning person failed to cope with an emotional crisis. Yet in a way her very failure helped her overcome her emotional problem. The phobias isolated her from the outside world, kept her at home, and helped to eliminate the accusation that she was a bad housekeeper. Giving up her job temporarily helped her keep control of her son. Successful utilization of environmental resources, such as the mental health agency, and the support of her husband helped this individual deal with the crisis and eventually return to a state of emotional equilibrium.

The attempts of these individuals to face hazardous situations led to the development of emotional crises because of the failure of adaptive psychological reactions. It was only when the patients were able to overcome the crises that they were able to return to a state of emotional equilibrium.

DISCUSSION

This account of hazardous environmental situations and the ways in which average individuals dealt with them throws light on the early emotional conflicts and on the steps that lead to the development of psychiatric symptoms, before such symptoms become crystallized into neuroses. It also possibly helps in understanding what constitutes mental health, since the individuals seen at the Human Relations Service were "normal" people. The question was, how normal were they?

Hazardous environmental situations are usually stressful, and maladaptive psychological reactions to them can at times lead to painful feelings. These feelings in turn may develop into an emotional crisis in one individual or emotional crises in members of his immediate family. Such emotional crises usually appear before the actual onset of psychiatric symptoms.

Several of the terms used require definition:

- A stressful situation is one which elicits painful emotions in an individual.
- A hazardous environmental situation is a universally experienced difficult or dangerous situation that becomes stressful to some individuals and not to others. Adolescence, for example, is not stressful to everybody, yet some individuals during adolescence develop emotional crises which may lead to quick deterioration and the onset of psychiatric symptoms. The hazardous situ-

ations affecting the 108 individuals seen have already been described.

- A painful state is an unpleasant emotional state of being (anxiety, anger or fear). Painful states usually arise at the time of stressful or hazardous situations.

- A reaction is a response to a stimulus that arises from the environment or from within the individual. "Reaction" here is synonymous with the term "defense psychological mechanism." On occasion environmental pressures may give rise to a painful state (anxiety, anger or fear) that in time may require a new set of reactions. A successful (adaptive) reaction is one that does not give rise to a painful state. An unsuccessful (maladaptive) reaction gives rise to a painful state.

- An emotional crisis is an intensification or aggravation of a painful state because of the failure of the reactions to cope with the situation, it is "a turning point for better or for worse." Thus it may stimulate the individual to utilize new sets of reactions to overcome the crisis successfully and return to an emotional equilibrium; or if the crisis cannot be dealt with adequately, it may further intensify the pain and give rise to psychiatric symptom formation. An emotional crisis is therefore a powerful internalized stimulus requiring further reactions.

Some individuals cling to and depend exclusively on the environment to solve their emotional crises. Others use exclusively pathological reactions. (Paranoid patients, for example, blame the environment for their own inadequacies, thus absolving themselves of any guilt.) Some suicidal individuals manipulate the environment dramatically in order to go on living. All these are unsuccessful ways of coping with the crisis.

The use of environmental resources exclusively as a reaction is dangerous, although it may work temporarily. The successful accountant in Case #3 used his house with three toilets in an attempt to protect himself from his own fears. He started to crumble when he found himself in a different environment (in the cruise ship). A dependence on something outside oneself which easily changes and fluctuates constantly, which is not built into the individual's character and is not under his control, creates a precarious situation. On the other hand, successful manipulation of the environment and its various resources—clinics, caretakers, agencies—helps in providing first-hand assistance to an individual facing an emotional crisis.

An emotional crisis in one individual can become a hazardous situation giving rise to emotional crises in other members of his family. For example, in Cases #1, #4 and #5 both husband and wife were in a crisis.

- A precipitating environmental factor is an environmental event that brings about the change from a painful state to a crisis.
- The mental health of an individual connotes his ability to master his internal environment, adapt to and utilize his external environment, and reach an emotional equilibrium, or a compromise, without being aware of painful emotions.
- Preventive psychiatric intervention is an attempt to help an individual overcome an emotional crisis and return to a state of emotional equilibrium between his internal and external needs. Such an intervention prevents further deterioration of emotional reactions but does not prevent the problems themselves. Emotional problems are due to conflicts occurring within the individual's own character, the origins of which are to be found in the first few years of

childhood. True preventive psychiatric work, therefore, can be done only with children. Yet the solution of an emotional crisis in a mother may indirectly affect a child at a crucial period of his emotional development and may actually prevent formation of harmful character traits in children. Fifty of the 108 individuals seen were mothers who had a disturbed parental relation with their children, and when the mothers were helped the children were also helped indirectly.¹

Using these definitions, one may attempt to describe the process that leads to an emotional crisis.

"At first an individual is in an unpainful state, but exposed to stress he enters a painful state."² A successful reaction to this stressful situation will eliminate anxiety, thus eliminating the painful state. An unsuccessful reaction will intensify the painful state. It is possible that an individual may temporarily reach a precarious balance and remain in a painful state.

The individuals who fail to return to an unpainful state, because of their inability to utilize environmental resources successfully and to mobilize adequate reactions, remain vulnerable. Additional stresses, arising either from within or from without, act as precipitating factors giving rise to an intensification, or a change for the worse, of the painful state. It is then that the individual is in a state of emotional crisis.

Here again, there are two ways of reacting to a crisis—successfully, by eliminating it and returning to a state of emotional

¹ Sifneos, P. E., "Psychiatric Work with Mothers Who Had a Disturbed Mother-Child Relation," *Mental Hygiene*, 43(April 1959), 230-36.

² Sifneos, P. E., Charles Gore and A. C. Sifneos, "A Preliminary Psychiatric Study of Attempted Suicide as Seen in a General Hospital," *American Journal of Psychiatry*, 112(May 1956), 883-888.

equilibrium, or unsuccessfully, by further aggravating and intensifying it. The emotional crisis thus has become an internalized painful stimulus demanding alleviation or satisfactory adjustment for the better, or leading to a further deterioration for the worse.

Individuals facing an emotional crisis must decide whether they should use all their resources to cope with it, even if this is at the expense of their general over-all functioning, or attempt to deal with both situations at once. Note that in Cases #1, #4 and #5 an attempt to do both failed and the crisis deepened. It was when the individuals involved utilized all their resources in an effort to overcome the emotional crisis, even becoming temporarily incapacitated, that they succeeded in their efforts and successfully returned to a state of emotional equilibrium. It was only then that they renewed their everyday activities.

An individual's flexibility, his ability to utilize all sorts of reactions, even pathological ones, and his concentration on resolving the emotional crisis may be useful assets in his effort to return to an unpainful state. On the other hand, an attempt to cope rigidly with the demands of everyday life and the use of inflexible reactions to face an emotional crisis, invariably leads to failure.

In the suicidal patient, environmental stress at times precipitates emotional crises. Maladaptive reactions intensify the awareness of painful emotions, and this in turn leads to a progressive isolation of the individual from the outside world. A point is finally reached when one and only one reaction is possible to alleviate the pain, and the patient attempts suicide.

Yet in some patients even the suicidal attempt becomes a tool with which to manipulate the environment. The support

they receive from their loved ones, the expression of dammed-up emotions, the fulfillment of their demands—all help their eventual return to an unpainful state. It is possible that if these individuals had turned for psychiatric help earlier, at a time when they were in an emotional crisis, their regression and final suicidal attempt could have been prevented.

In a mental health agency one deals with healthy, well-integrated individuals who seek help early. Help then may prevent the formation of the vicious circle of hazardous situation to painful state to emotional crisis that leads to environmental isolation and psychiatric symptom formation, and sometimes to suicide.

Most of the 108 individuals who were seen at the Wellesley Human Relations Service faced hazardous situations. Most of them were aware of painful emotions. Unable to deal with these emotions successfully, they had developed emotional crises. In some cases their reactions to these crises turned out to be fairly successful, and with psychiatric help they quickly returned to a state of emotional equilibrium. In other cases a series of maladaptive reactions to hazardous situations and emotional crises progressively led to the development of psychiatric symptoms. These patients required long psychotherapy and at times hospitalization.

Preventive psychiatric intervention attempts to reverse this maladaptive process, and to do so early. It helps the individual utilize his own adaptive reactions and the environmental resources, and to return to a state where there is no pain.

The description of normal people is difficult. There are no diagnoses that one can use, no tags, no labels. The usual nosological criteria are of little help. The concept of emotional crises is a dynamic one. It offers a way to describe the ever-changing

emotional processes of healthy human beings. The ways in which individuals face and overcome emotional crises is interesting to observe, and significant in its implications.

SUMMARY

In a suburban upper-middle class community 108 people were seen at the local mental health agency. Their complaints, reactions to hazardous situations and emo-

tional crises are described. Five cases are discussed in some detail.

An attempt is made to formulate theoretically a concept of emotional crisis. This dynamic way of viewing normal human beings in distress has practical implications for mental health.

ACKNOWLEDGMENT

The author wishes to thank Dr. Erich Lindemann for his innumerable helpful suggestions.

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Patient government in a psychotic population

This paper describes an experience in setting up patient government in a unit for acute intensive psychiatric treatment in a general hospital. Before dealing with our current experiences with the patient government program at Mercy-Douglass Hospital, we will briefly survey the experiences of other workers in the area.

HISTORICAL BACKGROUND

The idea that hospitalized psychiatric patients might be able to plan and organize some of their activities and take a measure of responsibility in formulating rules and

procedures for hospital living is not a new one, but it has long been met with considerable skepticism. Instances of autonomous patient organizations are rarely encountered in the literature; the descriptions of them which do appear paint them as exceptional and unorthodox but beneficial. In their earliest forms these organizations centered about some definite activity or project. As early as 1842, Dickens referred with admiration to the accomplishments of a sewing circle that he had encountered on a visit to an American hospital (5). Biener and Haldane (1) describe a social club organized in December 1939 in Runwell Hospital in England. They cite a number of cases to demonstrate how the club had been helpful to socially withdrawn individuals or to those with artistic needs or organizing and leadership ability.

Blackman (2) describes a literary club organized in 1940 by a group of 25 schizophrenic patients in a closed ward at Wor-

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chester State Hospital. The stimulus for the club came from within the group, and it received no "obvious guidance" from the hospital staff. Blackman comments: "It is in exposing the patients to a social activity with which they can readily identify themselves . . . that the club contributed most."

As interest has grown in the social structure existing in mental hospitals, and as the treatment potential of the "therapeutic community" has come to be realized, the functioning of autonomous patient groups has been seen within the context of the functioning of the mental hospital as a whole. Jones and others (6) discovered that discussions which were held for an educative purpose with a group of effort-syndrome inpatients during the World War II years came to be used by the patients for dealing with problems arising in ward living. In an industrial neurosis unit at Belmont Hospital meetings were held each week-day morning for all patients, approximately 100, and those members of the hospital staff who were able to attend. One function of these meetings was to deal with the patients' criticisms and suggestions about ward life. Bridger (3), describes a patient parliamentary body which played an integral role in the "social therapy" provided for a group composed chiefly of neurotic patients in a British military psychiatric hospital of 800 beds. Finally, reference should be made to a formalized program of patient government which was organized at Boston Psychopathic Hospital in 1948 (4, 5, 7). Its staff sponsors feel that it has been a major force in enabling the hospital community to approximate the larger outside community and thus serve as a more effective mode of treatment.¹

ORIENTATION AND GOALS

It is our conviction that disturbed interpersonal relations represent a factor of ma-

jor importance in mental illness. We regard the democratic orientation of patient government as one way of increasing the similarity of group living within the walls of the mental hospital and group living within the larger external community. Our goal in setting up a patient government program was to provide an opportunity for as much participation by patients as they could accept and meaningfully use, and for as much self-determination as could be fitted into the pattern of hospital life.

MODE OF OPERATION

The psychiatric unit of Mercy-Douglass Hospital contains 100 beds. It occupies two floors of an eight-story general medical and surgical hospital.

Patient government meetings are conducted once a week by the psychiatric residents assigned to three wards. It was decided that each group of patients would elect two representatives to a representatives' meeting to be held each week a few days following the general patient meetings. In addition to the patients' representatives, this meeting is attended by a staff clinical psychologist (who serves as chairman), one or more representatives from the nursing staff, the occupational therapist and more recently a recreational worker who has been added to the hospital staff.

It is the duty of the patients' representatives to bring to this meeting for discussion those matters which had been discussed at the separate patient meetings, and then to report back to the subsequent patients' meetings concerning the happenings of the

¹A more recent instance was reported in "Patient Government . . . A Case Study," by Joseph Stubbins and Leonard Solomon, describing a council of chronic schizophrenic patients in one of the buildings of the Franklin D. Roosevelt VA Hospital, Montrose, N. Y. This appeared in *Mental Hygiene* (October 1959), 539-544.

representatives' meeting. In general, issues which could not be resolved in the patients' meetings are further worked upon in the representatives' meetings. Sometimes it is necessary for the nursing representative to consult with the policy-making group in the nursing staff, and sometimes the psychologist must consult with the general staff before definite plans can be formulated. On some occasions, final policy decisions have to be made by the chief psychiatrist.

PROBLEMS AND ISSUES; EVALUATION

In our patients' meetings, many spirited interpersonal interchanges have taken place and considerable group pressure toward conformity has been exerted. However, the group has frequently given support to those individuals whose behavior was proving to be a problem. For example, while the patients manifested quite punitive attitudes toward an adolescent girl whose bouts of acting out were sometimes more than a little destructive of property, they were concerned lest she feel rejected, and they elected her to one of the offices in the patient government.

The patients struggled for a number of weeks with a frustrating situation which resulted when a few repeatedly monopolized the single public telephone available. They attempted to take upon themselves the task of limiting telephone conversations to a specific number of minutes, but found that the telephone monopolizers were unwilling or unable to cooperate and were sometimes retaliative and vindictive. Finally, discovering themselves unable to cope with the situation, they requested that the staff assist them in solving the problem. Although one immature but highly vocal individual insisted that if the staff were to control the use of the telephone, he would rather have it taken out altogether, he was voted down

by the majority and a solution to the problem was arrived at.

Another complaint which was frequently raised by the patients concerned the insufficient amount of activity available to fill the hours of the hospital day. Since we had functioned for the major part of our first year with one occupational therapy worker and no recreational therapist, this complaint was well founded in reality. The patients' initial response to this difficulty was to join forces with the occupational therapist, who also attended the meetings, to organize parties at Hallowe'en, Thanksgiving, Christmas and other holidays. Also, until the increasing size of our patient population made it unfeasible, an attempt was made to have a birthday party for each patient on his or her birthday. Then the group decided to have a birthday party each month for all whose birthdays fell within that month. In addition, requests for weekly dances and weekly movies were made and implemented through the persevering guidance of the occupational therapist.

The representatives' meeting provided one channel of communication between the several wards and was often the point of origin of inter-ward committees to work out such things as the program for a hospital entertainment which was being organized or the strategy for a fund-raising campaign that was contemplated. The meeting also provided an open reciprocal line of communication between staff and patients.

This form of patient government structure is being maintained, and while it has not overcome some obstacles as smoothly as had been hoped it has proved a meaningful and flexible framework for allowing patients to participate to the extent to which they are able at any particular time. Many aspects of hospital routine which the patients found especially frustrating have been brought to the staff's attention. Conse-

quently, more satisfactory policies have been evolved concerning such matters as visiting hours, methods of handling the patients' property, time for going to bed and rising, manner of serving meals, etc. Improved methods of operating have themselves improved morale, but it is also true that the patients' self-esteem has been enhanced by the fact that their suggestions are always considered and often put into operation.

One additional function of no mean importance served by the patient government organization should be mentioned. The meetings—particularly the representatives' meetings—have provided an opportunity for bringing to light and working out some of the tensions which have arisen between attendants and patients. The representatives are almost always widely informed about events transpiring on the ward, and they frequently reflect the tensions which some injudicious aspects of attendant behavior may have generated. For example, at one point the patients' representatives requested a meeting with the attendants to resolve some misunderstandings concerning the attendants' management of patients who were taken onto the hospital grounds for outdoor activities.

We feel that such instances of relatively free interchange of ideas and feelings have been highly important in establishing and maintaining hospital morale and community spirit, and that they have helped to prevent tensions from building up to a serious level.

It might be well to mention some of the frustrations encountered by those managing the patient government program. The acutely disturbed condition of a large proportion of our patient population and the rapid turnover in patients represent two major difficulties. At times an entire ward may be so disturbed that no representative can be elected. Or it may be that the repre-

sentative is so disturbed that he is able only to disrupt ongoing discussions. At times the patients seem to get into a waggish humor and deliberately select as representatives their most disturbed members. Then again, as the representatives, from the more disturbed wards improve and become able to function at a higher level they are either transferred to a less disturbed ward or discharged. As a result, a new surge of disorganization strikes the representatives' meeting and ongoing activities may temporarily fall by the wayside. Cycles of apathy and negativism seem periodically to make their appearance in the hospital unit. Consequently there may occur a long series of meetings in which next to nothing is said or in which patients indulge themselves in an orgy of purely destructive complaining. For some time one of the patients who had been playing an active role in a patients' meeting would introduce discussion with "What complaints are there today?"

As a result of these many frustrating circumstances the residents frequently became discouraged and disinterested and, of course, transferred their feelings to the patients. However, we feel that the advantages accruing from the patient government have far outweighed the disadvantages attendant upon its operation. We feel that it has made a definite contribution to over-all hospital morale, has given our inexperienced residents a kind of preliminary contact with group work, has bolstered the self-esteem of a number of our patients, and has made possible the working out of a number of problems of whose existence the staff might otherwise have been unaware.

CONCLUSIONS

A group patient government provides the following:

1. A method of increasing the similarity be-

tween life in a mental hospital and life in the external community.

2. A way of controlling deviant behavior with group pressure.

3. Group support to very disturbed patients.

4. A mechanism for increasing recreational activities.

5. An opportunity for patients to understand administrative policy and help formulate it.

6. Increased patient self-esteem.

7. Opportunities for patients to express annoyances and resentments.

8. Opportunity for residents to gain preliminary experience in working with groups.

9. A channel of communication between patients and staff, thus providing a way of improving morale through free interchange of ideas and feelings and an opportunity for bringing to light and working out tensions between personnel and patients.

10. Graded responsibility for participation of patients in an interpersonal relationship.

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JOHN A. LEWIS, M.D.

Psychological needs and services for nursing home residents

Statistics¹ on people in nursing homes suggest such an array of difficult psychological problems, one is not surprised to find that the staff are the ones who need the most specialized psychological assistance. This is because of the stress involved in helping aged, disabled people and, equally, because understanding by the staff of some elementary facts makes their work less difficult and the lives of their patients more pleasant.

It would be too much to expect that psychological specialists could be available to give individual care to nursing home residents except for special purposes. It follows that the staffs should expand their understanding of their patients and be able to provide psychological assistance as a part of their usual duties. The use by the staff of consultants is one way for the staffs to achieve such expanded understanding.

The general picture of patients in nursing homes is roughly as follows: Their average

age is 80 years; 90% are over 65 years of age; and less than 1% are less than 45 years. About 50% have mental disturbances; 20% are completely bedfast; 14% more are in bed most of the time. One third are incontinent of urine or feces, or both. Two thirds are women and two thirds are widowed. Less than one-tenth have a living spouse.

Patients of this age and in such poor health are not likely to be pleasant to be around. There are disagreeable odors and personality characteristics that try the tol-

Dr. Lewis, who is a psychiatric consultant to the U. S. Department of Health, Education and Welfare, made these remarks at the Department's Region III conference on nursing homes and homes for the aged held in Washington, D. C., February 18-20, 1959.

¹ "Nursing Homes, Their Patients and Their Care," U. S. Department of Health, Education and Welfare, Public Health Monograph No. 46, August 1946.

erance of the most tolerant and loving people. Those patients who have families seldom see them, because frequently unpleasantness arises when they do. There are, of course, exceptions, but this is more likely with the aged who are healthy and have developed inner resources over the years so that they are less dependent on others for satisfaction in living.

The behavior of the senile² is frequently annoying, displaying peevishness, depressive moods, foolish suspicions and a tendency to ramble on in long conversations without regard to what is important or relevant. Many in poor health are fearful of pain. Often their fears are baseless; on the other hand, there may be good ground for them. Memory of recent events is reduced. The patient may forget what she did with her glasses and, not finding them, accuse the staff of stealing. Personal belongings, because they are ties to a past life that was more satisfactory, become of great importance. Any attempt to remove them is likely to precipitate rage or mental confusion. The aged patient loses adaptability so that what he is sure of he holds on to with stubborn rigidity. Patterns of sleeping and eating are not easily changed and any attempt to do so is regarded by the aged person as an unfriendly act.

There are understandable reasons why the aged are stubborn, irritable and often depressed. They can remember well the days when they were in the prime of health and enthusiasm, and they have since experienced a slow decline in their physical and mental powers. Such control as they have over themselves and their environment

depends on their holding fast to what they have, their past, their possessions and beliefs. Any change causes a strain and if they cannot adapt to it they become hopelessly confused. To them, who look back wistfully to the "good days," the future looks gloomy.

In some seniles there is a flaring up of sexual feelings for the opposite sex. Infatuations may develop, inspiring silly, flirtatious behavior. Occasionally this results in unwise marriages or medicolegal action. Aged women, in addition, often have a return of motherly feeling for children and are likely to develop jealousies, hates and loves as complications of their attachments.

The successful care of the aged depends on understanding the patient. Each one is a special case with individual problems. A careful medical examination is of basic importance. Many discomforts caused by hemorrhoids, hernias, aching teeth, poor eyesight or hearing can be remedied and thus reduce sources of annoyance. Nutrition is likewise important. Many old people left to their own devices live on snacks and thus develop dietary deficiencies with easy fatigability, sore mouths or diarrheas.

The aged need less sleep than younger people but often take short naps. The administration of the nursing home should be planned so as to take account of this. Complete bedrest is seldom good for old people. It is likely to result in serious consequences, hypostatic pneumonia and depression. Many old people like to "putter around." This should be permitted because in doing so the old person is testing and confirming sensory and motor functions. It is well that the aged person maintain an attractive personal appearance. There is a tendency for them to neglect their clothing, hair and even personal hygiene.

Nolan Lewis³ believes that many old

² Lewis, Nolan D. C., "Mental Hygiene in Later Maturity," *Mental Disorders in Later Life*, edited by Kaplan, Oscar J. Palo Alto, Stanford University Press, 1956, 460-475.

³ Lewis, Nolan D. C., *op. cit.*

people are considered bores because of their tendency to relate over and over again the events of their past lives, forgetting that most of their acquaintances can repeat these stories verbatim. He suggests that the old person should resolve never to relate anything that happened earlier than the year just past. It might be difficult to get an old person to do this, but the suggestion would be helpful to those who are receptive.

Contrary to much opinion, unpleasant mental reactions in old people are often reversible. Careful attention to medical and dietary needs, simplification of the environment so that it becomes familiar and easy, making available familiar objects linked with the past, encouraging "putter-

ing" or other activities of interest to the patient may overcome unfavorable emotional reactions. For cases of depression, there are drugs, psychiatric treatment, one or a few electric shock treatments, which are highly effective.

In summary, providing individual patients with good care, taking into account their physical environment, medical needs, emotional reactions, and social factors is equivalent to providing psychological services. To improve staff understanding of the patients, personnel can get help from specialists in mental health. Psychological specialists should be used for individual patients only for special problems that cannot be managed by the nursing home personnel.

Psychic exploration

In a dream, an aftermath of void
Where ripened fields exposed to twilight
Suggest horizons confused by glows
Of distilled insights, seldom uttered.

Affects seek assurances
Ringed with primeval intrigues.
Of solitude's anonymity,
In hopeful daze and regression's womb.

ARTHUR LERNER

HERBERT A. OTTO, PH.D.

Developing a mental health program in a teacher-training institution

It is the purpose of this article to review the organization and development of a mental health program within the college of education of a state university. An evaluation of the different aspects of the program will be presented and conclusions drawn based on program development. Finally, a number of recommendations will be made relevant to the establishment of similar programs.

The historical background of the program is briefly as follows. In 1949 the Division of Mental Health of the Georgia State Health Department provided funds to establish the position of professor of mental health in the College of Education at the University of Georgia. The project was to be a cooperative effort of the college of education and the division of mental health with administrative supervision pro-

vided by the dean of the college of education.

The objective of this project was to develop a mental health program functioning within the framework of a teacher-training institution. For a number of reasons the position established at the university was filled for only short periods until the summer of 1952. This marks the beginning of the present program with the appointment of the writer to the position. The mental health program at the college of education can be divided into two areas, the teacher-training program and services to specialized school personnel. A third area of functioning, which will be touched on only briefly, is in relation to the community-university mental health program.

TEACHER-TRAINING PROGRAM

It is generally recognized that the school-age population offers one of the best opportunities to pioneer in developing programs

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which strive to promote mental health and prevent mental illness by focusing on early recognition and treatment of emotional illnesses. This includes training teachers in how to recognize symptoms, how to give basic supportive help, and how to make adequate referrals and utilize treatment resources. School-related mental health programs also center on the development of mental health by such means as helping teachers gain understanding and skills which will enable them to provide the type of classroom and learning atmosphere conducive to mental and emotional health. Such programs focus on the promotion of positive mental health by helping pupils to discover, strengthen and develop hidden potentialities, talents and capacities.

Programs with an emphasis on the development of positive mental health are based on a recognition of the importance of the teacher as a key person in the child's emotional maturation and his character and personality development. It is a fundamental hypothesis of such programs that if the teacher can be given an increased measure of self-understanding, some basic knowledge of personality dynamics and a grasp of basic mental health principles or concepts, he will be in a better position to create the type of classroom environment which will foster healthy growth. Creating this type of classroom environment aims at building strengths into the students, providing the best possible conditions for learning and encouraging the development of individual capacities and potentialities. From a different point of view, such programs attempt to strengthen the professional competencies of the teacher by enlarging his knowledge of the factors which contribute both to mental health and mental illness, and by giving him an understanding of the important role that he plays in contributing to the mental health of his students.

The teacher-training program at the University of Georgia can be divided into two subgroups: (1) in-service training with teachers in the classroom and (2) on-campus teaching of students and consultation with the college faculty. In the first three years of the program's existence a relatively large amount of in-service training was undertaken. This was done for two reasons: one, the relatively slow development of the on-campus phase of the program, and two, it was thought that because in-service training would span a considerable area of the state, some immediate and direct benefits would be extended to school children.

IN-SERVICE TRAINING WITH TEACHERS IN THE CLASSROOM

On the basis of repeated experience and continuous evaluation of approach, procedure and method, a framework was developed for conducting in-service training workshops on mental health for teachers. Briefly, a method of presentation was developed with the view of creating the type of learning climate which would facilitate free thinking and discussion around the needs and level of development of the participants. It was found that such a climate could most satisfactorily be attained by concentrating on the quality of relationships existing between workshop participants in the beginning of the workshop session and by exploring how the quality of relationships influences the learning process. The objective was for workshop members to get to know each other, to lessen social and interpersonal isolation, to create a relatively status-free climate (1), to channel anxiety constructively, and to help group members assume increasing responsibilities in the learning process. It was a basic aim to develop the type of learning climate which would foster attitudinal change as well as the retention of information and

facts. The underlying philosophy, techniques, methods and materials used has in part been previously detailed (2).

A total of 76 in-service training workshops and seminars were conducted over a five-year period. (Eleven additional training sessions and workshops were conducted with public health nurses and four with ministers.) Approximately 1,368 teachers were reached by this means. An analysis of questions submitted by teachers in these in-service training sessions revealed that the following topics were most often chosen in the order of importance:

1. Causes of mental illness.
2. Symptoms and treatment methods.
3. How can we help a disturbed child or person?
4. Is mental illness hereditary?
5. Our own mental health.
6. How to work more effectively with parents and administrators.
7. What are preventive programs in mental health?
8. What is the state mental health program and what resources are at our disposal?
9. What can you do about a person who needs psychiatric help?
10. Help with specific cases (3).

In 1956-57 a survey was made of approximately 70% of the school systems and school faculties where in-service training sessions had been held. A number of findings and outcomes were noted. These are listed in order of importance—that is, the number of times mentioned:

1. Teachers reported that as a result of the training sessions they believed themselves to be better equipped to understand their students and/or colleagues.
2. Teachers stated that they felt more self-confidence in handling situations involving

feelings (such as disturbed students in the classroom, and upset parents in parent-teacher conferences).

3. Teachers also reported that they were more sensitive to signs and symptoms of emotional disturbances in children and were more aware of the importance of early detection of symptoms as an aspect of prevention.

4. Next, they indicated that they had a greater awareness of the need for mental health education and the need for clinical and psychiatric facilities.

5. They claimed an increase in their knowledge of available mental health resources and referral procedures as well as the state mental health program.

6. Teachers noted a gain in self-understanding and awareness of the importance of their own mental health.

7. Finally, an increased understanding of mental illness, the mentally ill and treatment methods was reported.

Some side-effects of the training program were noted. First, there was an increase in the use of available mental health resources. For example, referrals to visiting teachers and guidance personnel showed demonstrable gains. In some communities, civic groups and PTA's were stimulated to schedule talks and films on mental health.

One of the most important findings of the survey confirmed observations made during the first year of conducting workshops. It was found that if school administrators were not active participants in the training sessions, teachers seemed to find it difficult to put newly acquired ideas, principles, techniques and methods into practice. Less than half (approximately 45%) of the training sessions had been attended by school administrators. Due to a number of factors, such as a reduction in travel funds and ex-

panding requests for services within the college of education, activities in respect to in-service training workshops were rapidly reduced over the last two years of the program's functioning. Aside from the above stated reasons, it was our conclusion that the energies and resources of the program could more profitably be concentrated on the training of student teachers.

An evaluation of the in-service training program must take into account that the effectiveness of the program was limited by the failure to encourage a larger percentage of school administrators to participate in the training. However, this dearth in the attendance of school administrators does not seem to be an isolated phenomenon. It has also been observed at mental health institutes and workshops conducted in other parts of the country (4).

It is of interest to note that even though the school administrators did not avail themselves of training, they did seek individual consultation about particular problems. Principals and superintendents of the localities where in-service training or other sessions were held asked for consultation in regard to cases of seriously disturbed children, personnel problems, juvenile delinquency and school morale problems. It is estimated that in the course of approximately 60% of the in-service training sessions such help was given to school administrators, both formally and informally.

The fact that the teachers ranked an increase in self-understanding and an increased awareness of the importance of their own mental health as next to the bottom of the list raises a series of questions:

Does this indicate that insufficient emphasis was placed on this important area? On the other hand, since a significant amount of time was devoted to the exploration of these subjects, is this indicative of the participant's resistance to being exposed

to an effort to stimulate greater self-understanding? Or perhaps is there an implication in this rating that the participants are dissatisfied with their accomplishments in this area?

It is the writer's conclusion, based on interviews with workshops members subsequent to the survey, that a combination of these factors was operative. As one teacher put it, "At first I thought we might be getting in too deep and I was pretty uncomfortable. Then I realized how far we had to go in self-understanding and that we had really just begun. Also, the responsibility we faced became more apparent. Six months after the workshop I was dissatisfied with what we had accomplished. I believe we did not gain enough self-understanding."

ON-CAMPUS TEACHING OF STUDENTS AND FACULTY CONSULTATION

Opportunities for mental health education of teachers exist throughout the activities of the teacher's college—in the orientation of students, health courses, counseling and guidance, selection of students, faculty-student relations and student teaching, placement, as well as follow-up of placement. Although it was deemed important to utilize opportunities in these areas as they developed during the growth of the program, the primary program focus was on the teacher-training curriculum.

Rather than develop a separate course on mental health to be added as another offering to the existing list of classes, it was our thinking that mental health understanding needed to be integrated throughout the curriculum. At least one study completed since the initiation of the program gives a clue that a single course in mental hygiene "does not necessarily increase a teacher's ability to affect interpersonal relationships in the classroom" (5).

On the other hand, if mental health could be integrated into the curriculum the student would be exposed to mental health content and material throughout the various phases of his professional training and development. On this basis it was decided that mental health could most effectively be made a part of the teacher-training curriculum by encouraging faculty members to use the writer as a consultant.

Consultative services focused largely on developing units on mental health specifically tailored to the needs and framework of the class to which the consultant had been invited to participate by the instructor. In the initial period, 1952-54, a slow rate of growth was experienced. Requests came primarily from the summer workshops and were of the one-lecture or single-presentation variety. However, during the school year 1955-56 requests for consultation with classes more than doubled. An interesting change occurred in that the duration of presentations ranged from three-week units to a single class meeting and the requests came from regular on-campus classes. Since that time there has been a steady growth of requests from professors who asked that units on mental health be presented within the framework of a particular course.

To illustrate the growth of these services, during the period 1952-54 approximately 10% of the total number of students engaged in professional training for teaching careers were reached through such units. In 1955-56 approximately 50% were reached; in 1956-57, 60%; and in 1957-58, approximately 70%. For example, in 1957-58 units on mental health were presented in the following courses: educational psychology, problems in school health education, introduction to exceptional children, physical education, school health education, organization and administration of physical education, education of children with motor

handicaps, voice and articulatory disorders of speech, curriculum planning, teaching procedures, and the psychology of adolescence.

The above distribution of courses indicates that a significant proportion of students were brought into contact with mental health understandings, principles and concepts at various points in their professional training and development. It is expected that as a consequence of this multiple exposure to mental health content from the different perspectives of specialized subject matter, the student will gain an appreciation of the application of mental health principles and practices to whatever classes or subjects he may be expected to teach in the future.

To encourage the development of closer working relationships with the faculty, the writer, for a two-year period of time, was given a regular assignment teaching classes in educational psychology. A similar regular teaching assignment was made for the summer session with an appointment as staff member of the summer workshop on educational planning and development. This was a flexible assignment which allowed time for consultation with other classes. The summer workshop, which has had an average attendance of 120 students, was composed of primary and secondary teachers, supervisors, visiting teachers and administrators. The overwhelming majority of the participants were graduates who came to the university for the purpose of renewing their certificates or to work toward advanced degrees. As a part of this workshop, so-called special interest groups were organized around such subjects as recreation, art and mental health.

Initially, enrollment in the mental health groups compared well with that in other groups. Over a four-year period attendance steadily increased, leading to such a condi-

tion of overenrollment in mental health groups that for the last two years students have had to be referred to other groups. The content for the mental health groups was divided into three areas: mental health for the classroom, mental health for the teacher, and group process and mental health.

Similarly, (when requests were received by the college of education to conduct community laboratory workshops for some of the larger Georgia school systems), the writer was assigned to these workshops. The workshops carried graduate credit and were conducted by a team of traveling faculty members known by their colleagues as "the flying squadron." These system-wide workshops met bi-weekly for a full 5-hour period throughout the school year. Groups were organized only if they were requested, and workshop classes on mental health had a heavy enrollment in all school systems where such classes were offered.

Evaluation of the effort to integrate mental health content into the teacher-training curriculum leads to a number of observations. Since the program was essentially a pioneering venture, very little was available in the nature of guide-lines for program development. The framework, approach and method of operation had to be developed while functioning *in situ*. Without the trial and error process involved in this, program growth would probably have proceeded at a somewhat faster pace.

Faculty members were uncertain what the function of the writer was and how to utilize a mental health specialist. This confusion was further aggravated by the growth processes implicit in the development of a new program. It should be pointed out that no effort was made to "sell" the program as such. Word-of-mouth communication about how the writer was being used and student response to units on mental

health proved an effective means of providing requests for consultative services.

There is some question whether there should not have been an implementation by the written word, such as a semi-monthly publication describing program activities. It is of interest to note that student and teacher interest in the subject of mental health seemed to outrank college faculty interest considerably. This was particularly noticeable in the initial years of program development.

Finally, in the early years of program growth, some colleagues seemed to interpret the presence of a person specializing in mental health as a threat. This was evidenced by numerous jocular remarks colleagues made about their own mental health, veiled reference to the writer's mental health or lack thereof, and suggestions that the writer was analyzing the behavior of colleagues. It seems plausible that the development of the program was in part contingent on the resolution of these images and resistances.

Another area of functioning in relation to the faculty can be described broadly as an in-service training approach. This consisted of informal conferences, distribution of materials, and consultation about the use of suitable mental health films. The objective was to help broaden faculty understanding of mental health. Faculty members have also sought help with referrals and counseling problems. Department heads have asked for consultation about emotional problems of staff members. Formation of a committee was supported to study the area of mental health in relation to teacher training. This committee was composed of key faculty members and representatives from the psychology and sociology departments. Meetings were held over a period of two years and a series of specific recommendations were submitted to the faculty.

SERVICES TO SPECIALIZED SCHOOL PERSONNEL

From 1952 to 1958 the professor of mental health was the director of the visiting teacher-training program and responsible for the development of this program. This was a graduate degree program for visiting teachers (known as school social workers in other parts of the country) and entailed the usual duties of the director of a graduate program. The one-year master's degree program is administered by the college of education as there is no school of social work for white students in Georgia. With the full recognition of the inherent shortcomings of such a training program, it was nevertheless thought advisable to give visiting teachers a certain fundamental background and training in social work rather than none at all.

Appointment to the directorship of the training program was in part based on the recognition that visiting teachers are key front-line personnel in the mental health effort. A reorganization and strengthening of the training program leading to the master of education and master of science in education degrees was undertaken by introducing a heavier concentration on social work courses and on courses on family development, sociology and psychology.

A diversified program of in-service training was conducted with specialized school personnel. A basic premise was that the professional skills of the persons rendering specialized services could be increased and refined. This was accomplished by offering additional training in such areas as personality dynamics, basic casework and interview techniques. The latest relevant research findings in mental health and related areas were employed.

An extensive program of in-service training was carried on in conjunction with the

state professional organization of visiting teachers. Work concentrated primarily on conducting casework seminars and teaching basic principles of community organization. To illustrate the scope of the work, from 1952 to date a total of 69 casework seminars, workshops and in-service training meetings have been conducted. Seventy-five percent of this effort was concentrated in the first two years of the program's functioning, as there was no person at the supervisory and administrative level in the State Department of Education to implement in-service training activities.

Consultation and training services were also extended to state guidance personnel and school supervisors. Again, most of the work was done in collaboration with the professional organizations of the two groups. Services to specialized school personnel were varied and included addresses, film presentations as well as participation in in-service training sessions as a consultant, resource person or discussion leader.

An evaluation of the work with specialized school personnel leads to a number of conclusions. The administrative decision to allot a large amount of energy and time to the in-service training of the visiting teachers in the early years of this program undoubtedly resulted in a strong identification of the writer with the visiting teacher services. This may have prevented other specialized school personnel from utilizing available services as fully as they might have if a more appropriate balance in services had been maintained. There is also some reason to believe that more of a focus on a systematic and repeated interpretation of the state mental health resources, program and objectives was and is needed. Finally, to enhance understanding and communication between the mental health teacher-training program at the university and the respective professional organizations and

state level administrative branches of specialized school personnel it would have been helpful to circulate yearly program reports and a summary of aims and objectives.

A final major aspect of the total plan was the development of a community mental health program which would draw on university mental health resources in the establishment of a clinic facility. Following extensive work with community organizations, financing of the clinic was assured. Organization of the mental health clinic awaits appointment to the now-vacant post of health commissioner. (A separate article is planned on this phase of the program.)

CONCLUSIONS AND RECOMMENDATIONS

Certain broad conclusions emerge from the growth struggles and gradual maturation of the program. These may be of interest in the planning of mental health programs to be established within the framework of teacher training institutions:

1. It would have been helpful if the faculty had been included in program planning. This could have been done by conducting a survey as to how the college staff would see a mental health person making a contribution to the teacher-training program. A basis for program building would thereby be furnished.

2. Acceptance of the mental health person as a member and part of the faculty would have been facilitated by assigning a regular, but minimum, teaching load at the onset of the program.

3. In the early phases of program development, many questions, problems and matters relating to mental illness were brought up. These had to be handled and cleared away before there was a readiness to deal with mental health *per se*. The writer's clinical

background was of considerable value in this connection. It would have been even more helpful had the writer had some experience as a teacher or school administrator.

4. The program would have been considerably strengthened if a continuing focus on research had been developed as an integral part of the total plan. This would also have afforded a major opportunity for faculty sharing and participation in the development of the program.

5. The scope of responsibilities for the person or persons who are constructing and developing a program should be carefully planned and explicitly outlined with regard to realistic limitations. It is easy to become overly enthusiastic over the scope of a new program. It should be clear from this article that the program described actually encompasses three full-time programs. This is not to decry the values gained from this pioneer project. It is to point out some of the pitfalls inherent when personnel is spread thin.

6. It is of considerable importance to invite a maximum involvement of administrative superiors in program planning as well as to keep them up to date on program developments. This would seem to be especially desirable in the area of mental health education, a relatively new field and a program entity which is still struggling for recognition.

The program at the University of Georgia was conceived as a demonstration project. It was one of the first such projects in the country and was basically a pioneering venture. As a result, no clear-cut definition of commitments and responsibilities were worked out by the college of education and the state division of mental health in regard to the future of the program. Instead,

the program has been carried on a year-to-year basis with an understanding as to its continuation but with no definitely formulated commitments as to its future. It is of particular importance that there be clear commitment in regard to financial support of such a program. Administrative responsibility and financial responsibility should be carefully coordinated.

It is the writer's conclusion that if similar programs of mental health in education are organized, these would be strengthened if a minimum of five years be designated as a demonstration period. At the end of this time an evaluation may be undertaken by cooperating institutions. It would strengthen such programs if both institutions, at the onset, would clarify their expectations and define their possible commitments for the future of the program, contingent, of course, upon the evaluation at the end of the five-year period.

The field of mental health in education offers manifold opportunities for developing preventive programs at a comparative minimum of cost while reaching a maximum

of the growing population. It is an area in which considerable basic groundwork and pioneering is being done but which is also at a stage of growth where sound programs can be built and results demonstrated. It is hoped that this article will stimulate further thinking and exploration in the development of mental health programs in education.

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Costs of alternatives to hospitalization

The economics of mental health has not received the attention it deserves. Treatment delays and inadequacies are repeatedly explained in terms of limited budgets. Yet there has been little careful study of treatment costs. Appraisals of program costs are seldom keyed to treatment results, so that the real costs of returning the patient to social responsibility can be missed.

In these days when difficult decisions are being made about the allocation of tax dollars among highway construction, schools, mental health and missile programs, it seems imperative that mistaken economies be avoided. The cheapest program per hour of treatment is not necessarily the cheapest from the viewpoint of the total cost of returning patients to social usefulness; neither is the most expensive program in the short run necessarily the most expensive in the long run.

Another aspect of the problem is the need to provide psychiatric service within

the range of the ability to pay of the great middle-class population. Out of the past era of hopelessness has grown a dependence on the State to assume a large part of the cost of psychiatric treatment. Although this was appropriate at a time when the outlook for most patients was long-term hospitalization, with the more favorable picture today the average family should be as well able to pay for psychiatric treatment as for medical or surgical care.

Butler Health Center is a private non-profit institution. It was set up to provide a flexible treatment program, providing not only intensive in-service treatment but a variety of alternatives to hospitalization such as out-patient treatment, day hospital, night hospital, home care, and other part-

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time hospitalization. These services are quite flexible, with easy movement of the patient from one to another determined largely by clinical indications. There is some bias against long-term hospitalization, considering that it segregates the patient from community life to such an extent that in itself it creates handicaps making it difficult for the patient to return to the community. A grant from the United States Public Health Service financed the project to study these alternatives to hospitalization, and this paper presents the economic aspects of the program. The setting for the study provided some unique opportunities to compare costs of different treatment methods, yet the results should have general application. No reason is seen for their not being applicable to the treatment picture in all parts of the world where professional services are similarly paid.

An economist looked at these treatment programs, made his own selection of cases for study, worked out costs of treatment related both to cost per hour of hospital services, and total cost for the illness. The economic picture here presented can sharpen our perspective on this aspect of our work.

SCOPE AND METHOD

What is examined here is the cost of therapeutic treatment programs which are alternatives to prolonged hospitalization. The study covers the period from March 1957 through December 1958 and includes data on 42 patients chosen at random from a

list of 238 alternative patients. Each of these patients was either recommended to Butler Health Center for hospitalization or was seriously considered for hospitalization at or near the date of admission. Most were admitted, instead, to the day-patient or the out-patient departments, while six received temporary in-service treatment (14 days or less).

The study is divided into three parts. The first two refer to the cost to the mental health center:¹ 1) comparison of the relative costs of different *patterns* of treatment, all of which are alternatives to hospitalization, and 2) comparison of the cost of these alternatives as a group with the cost of hospitalization itself. The third part refers to the cost to the community in which the mental health center is located. It compares the cost to the community of different patterns of alternative treatment and the cost of alternatives versus hospitalization.

From a broad viewpoint the mental health center is regarded as performing three basic functions: 1) psychiatric service, 2) research and 3) professional instruction. Each function is performed at some cost, and all costs are classified as variable or fixed. Variable costs are defined as those which are assignable to the treatment of individual patients and which vary with the amount of treatment rendered. Fixed costs are those which are unassignable and which do not vary with the amount of treatment rendered to any one patient.

The following items were found to enter into the cost of treatment.

Variable cost items

1. Intake and diagnostic
2. Individual psychotherapy
3. Group psychotherapy
4. Psychological testing
5. Rehabilitation counseling
6. Social casework
7. General nursing care

¹ In estimating the cost to mental health center, the eventual incidence of the cost of operation is not considered. Subsidies in the form of research grants, endowments and gifts are ignored. Since our interest is in the cost of functions performed rather than the cost to the institution, costs are calculated as if Butler Health Center would perform its functions regardless of subsidization.

8. Visiting home nursing care
9. Occupational therapy
10. Lab and X-ray
11. Drugs
12. Electric shock therapy
13. Psychiatric administration of patients' practical affairs, program supervision and staff conferences.

Fixed cost items

1. Research and professional instruction
2. Fixed cost of physical plant: depreciation, administrative salaries, care of grounds, heat, light, etc.

Since the variable costs depend upon the amount of service rendered, the amount of each type of service for each patient was tabulated from institutional records and its cost computed. From the items which involve fixed costs, all patients benefit as a collective group. Being unassignable, the total fixed cost was allocated over all patients. Since the costs of research and instruction are practically inseparable, the combined cost of both was estimated and allocated equally over all patients in the census, regardless of the department in which treatment was received. The fixed cost of physical plant was pro-rated departmentally, depending on the degree to which the several departments utilized the physical facilities. Then within each department the cost was allocated equally over all patients in the census of that department.

COSTS OF DIFFERENT PATTERNS OF ALTERNATIVES

The service items giving rise to variable costs listed above (except lab and X-rays, drugs and program supervision) can be expressed in hours of service. For each of the service items listed by hours the cost of rendering one hour of that service was estimated. It includes not only the cost of that hour of service but also all associated costs such as secretarial time, report writing and recording, test interpretations, cost of

materials, and so on. For instance, for one hour of individual therapy this cost would include the cost of one hour of the therapist's time, the cost of the therapist's time required for report writing, the cost of secretarial time, and the cost of materials and supplies used.

After the cost per hour for one type of service was computed, it was multiplied by the number of hours of that service rendered to each patient to get the total cost of that service to the patient. For a given patient the total cost of all the items was summed and divided by the total number of service hours to obtain the *variable* cost per service hour for that patient. To this was added the *fixed* cost per service hour to get the *combined* cost per service hour. Total fixed cost was divided by what hospital officials regarded as the "normal" census of patients in each department with the given plant and given size of staff to find the optimal total fixed cost per patient. This figure was then reduced to fixed cost per service hour by dividing by the total number of service hours for each patient.

Some definite patterns of treatment emerge. These have been classified and their costs recorded in Table 1. A group of 19 patients formed a pattern characterized by relatively large amounts of occupational therapy (over 80% of total service hours) and group therapy (10% or less of total service hours). This Pattern A shows the smallest cost per service hour per patient because of the relatively large ratio of patients to staff in the treatment pattern. It also reflects a heavy dependence on general milieu therapy. The cost of Pattern A is only about 59% of the cost of Pattern B, the pattern which shows the second smallest cost. It is approximately 18% of the cost of the most expensive pattern of treatment, Pattern E.

Pattern B contained larger amounts of

group therapy (G.P.) and less occupational therapy (O.T.), compared with Pattern A. It also shows a greater cost per service hour per patient. Pattern C, with temporary in-service and occupational therapy dominant, is an intermediate cost treatment. Statistical tests indicate that its cost does not differ significantly from the cost of Pattern B (see footnote to the Table).

Finally, the most expensive patterns of

treatment are those characterized by a low ratio of patients to staff and treatment by more costly personnel (because of the greater training required). The higher costs of individual therapy (I.T.) and psychological testing are reflected in Patterns D and E, which do not differ significantly.

A meaningful cost comparison must take into account the effects produced by different patterns of treatment. For example,

TABLE I

*Costs per service hour to the health center for different patterns of alternatives treatment **

PATTERN OF TREATMENT	NUMBER AND PERCENTAGE OF PATIENTS		AVERAGE VARIABLE COST PER SERVICE HOUR PER PATIENT	AVERAGE FIXED COST PER SERVICE HOUR PER PATIENT	AVERAGE COMBINED COST PER SERVICE HOUR PER PATIENT
	No.	%	\$	\$	\$
Pattern A: (1) O.T: more than 80% (2) G.T: 0 to 10%	19	45	.68	1.44	2.12
Pattern B: (1) O.T: 65 to 80% (2) G.T: 11 to 20%	9	21	1.26	2.33	3.59
Pattern C: (1) In Service: 1 to 14 days (2) O.T: 50 to 70%	6	14	2.19	2.44	4.63
Pattern D: (1) I.T. more than 50%	5	12	6.78	3.84	10.62
Pattern E: (1) I.T: 20 to 40% (2) Remainder generally distributed with more than average testing	3	8	5.79	5.57	11.36
Totals:	42	100			
Average for 42 Patients			2.09	2.32	4.41

* The null hypothesis that there is no difference among the mean costs of different patterns of alternatives in the statistical population was tested. Using the 5% level of significance it was found that the difference in cost between Patterns B and C is not significant. Neither is the difference between Patterns D and E. All other differences in cost are significant.

Pattern D may cost roughly five times as much in dollars as Pattern A, but it may prove to be more than five times as effective in terms of therapeutic achievements. Based on the results produced, then Pattern D would be less costly than Pattern A. To meet this problem a psychiatric evaluation of each patient was given by at least three staff members who had close contact with the patient. Evaluation as of the date of admission was as follows:

Sick, disabled or disturbed:

- Mildly—1
- Moderately—2
- Very—3

For computation purposes the numbers in the parentheses refer to the code used to compute averages. Evaluation as of the date of discharge contained the categories:

- Much worse—1
- Moderately worse—2
- Mildly worse—3
- No change—4
- Mildly improved—5
- Moderately improved—6
- Greatly improved—7

From the numerical scale assigned to each category the average for the patients in each pattern was computed. The larger the average (for both admission and discharge) the greater is the success achieved by a pattern. The average evaluation at admission for all 42 patients is 2.21, and at discharge 5.68. No statistically significant difference could be found among the various patterns. Therefore, we may conclude that the dollar estimates as computed for these patients reflect real relative differences in the costs of patterns of alternatives treatment.

Certain further inferences may be drawn from these results. There are two dominant influences which contributed to low-

cost treatment: 1) treatment patterns involving a high ratio of patients to staff and where general milieu plays an important role, and 2) treatment patterns which utilize staff with lesser formal training under the supervision of one or more senior staff members. If, as the data do indicate, these methods of psychiatric treatment can be used effectively, the cost of alternatives treatment can be greatly reduced for patients for whom these types of treatment are appropriate.

At this point a word of caution should be injected. The cost per service hour provides a convenient standard by which different patterns of alternatives to hospitalization may be compared. This does not imply that any direct cost comparison can be made between these alternatives and long-term custodial hospitalization. The general frames of reference and the objectives of these two psychiatric techniques are entirely different. Nor can a valid comparison be made between these cost estimates for alternatives and cost estimates for mental health centers with radically different physical plant or scale of research—if the mental health center engages in research at all. For these two factors will largely determine the size of fixed costs. However, the cost of alternatives treatment as a whole may be compared with non-custodial—that is, intensive-treatment—hospitalization (such as that pursued at Butler Health Center). In this case the goals of psychiatric service, the size and state of physical plant and the scale of research are similar if not identical.

COST OF ALTERNATIVES VERSUS COST OF HOSPITALIZATION

The peculiarities of in-service treatment—particularly room and board, nursing care and general milieu—demand another approach for the comparison of hospitaliza-

tion with alternatives as a group. Total cost comparisons are more meaningful for this purpose. Consequently, the total cost for an average alternatives patient is compared with the total cost for an average in-service patient.

The total cost over the entire duration of treatment was tabulated for each of the 42 patients, and the weighted average was computed. How much in-service treatment could be given for this same total cost? The cost per patient per day for in-service was estimated for the period January, 1958 to December, 1958 inclusive.² This figure was divided into the total cost per patient for alternatives treatment to obtain the number of days of in-service which could be given for the same sum. It amounts to 23.41 days.

However, the average length of stay for in-service patients for the same period is 36.30 days. Consequently, the total cost of alternatives treatment is less than the total cost of hospitalization. How much less is determined by the ratio

$$\frac{\text{Days of treatment for same cost as alternatives}}{\text{Actual days of in-service treatment}} = \frac{23.41}{36.30} = .64.$$

² The estimate omitted geriatrics patients and chronic psychotics as not relevant to comparison with alternatives.

³ Using the scale described in the previous section, the mean evaluation at admission for the 42 alternatives patients is 2.21 with a standard deviation of .49 and a range of 1.17 to 3.00. The mean evaluation for hospitalized patients is 2.41 with a standard deviation of .52 and a range of 1.56 to 3.00. For the alternatives patients the mean evaluation at discharge is 5.68 with a standard deviation of .90 and a range of 3.78 to 7.00. The hospitalized patients show a mean evaluation at discharge of 5.65 with a standard deviation of .73 and a range of 4.08 to 7.00. The null hypothesis that there is no difference in the means for the two groups at admission and at discharge was tested at the 1% level of significance and accepted.

In other words, by an expenditure of less than two-thirds of the cost of hospitalization, the same "degree of cure" can be achieved for patients of a comparable degree of mental illness.

The comparison is valid, of course, only if the alternatives patients are psychiatrically comparable with the in-service patients. That the in-patients showed roughly the same degree of illness and improvement as did the alternatives patients is substantiated by a psychiatric evaluation identical with that used to compare different patterns of alternatives. A sample of 50 discharged in-patients was chosen at random from a list of all discharged in-patients for the year 1958. The degree of illness and improvement of these hospitalized patients was compared with the degree of illness and improvement of the alternatives patients. No significant difference was found.³

COSTS TO THE COMMUNITY

The costs of mental illness to the community as a whole encompass many kinds of financial burdens, each calling for an expenditure that must be borne by the patient, his family or some community agency. The costs include the actual monetary outlay to the psychiatric institution, care of dependents, costs of property damage, costs of social rehabilitation, and so on. From a practical viewpoint it is impossible to obtain reliable empirical data on several of these costs. For this reason we shall approach the costs to the community in terms of three observable phenomena: 1) the monetary outlay to the psychiatric institution to meet the cost of treatment, 2) the income foregone by the patient during the period of treatment, and 3) the care of dependents.

We shall assume that the first of these is equal to the costs incurred by the mental

health center, which were discussed in the two previous sections. That is, either the patient or some other members of the community pay this full cost by direct outlay or by community-subsidized psychiatric treatment. The second cost item, loss in the patient's income, reflects a net loss in economic productivity for the community as a whole. Assuming relative full employment of community resources, the third component also reflects a decline in productivity as a result of the diversion of resources (human and non-human) from other productive functions in order to carry out the economic function formerly performed by the patient.

To compute the cost component consisting of monetary outlay the estimates of the preceding sections were used. The cost per day was multiplied by the number of days of treatment to get the total outlay. To this was added the net income lost from unemployment during the period of treatment.⁴ Finally, the third component, expenses for care of dependents (if any) per day, was calculated for each patient and multiplied by the number of days the patient was away from home for psychiatric treatment. The sum of these three components yields an estimate of the community costs for each patient.

The total cost for each of the alternatives patients was computed and divided by the number of patients to find the average cost per patient for the alternatives as a group. This figure is compared with the community cost of hospitalization for patients of roughly the same income (same occupation), the same number of dependents and the same degree of mental illness. It was found that the cost to the community for alternatives treatment is approximately 41% of the cost to the community of hospitalization.⁵

The reasons for this substantially lower ratio as compared with the cost to the health

center (.64) are clear. The total monetary outlay was less for alternatives, and it was spread over a somewhat longer period of time. Moreover, the smaller costs from loss of employment and care of dependents further reduced the ratio. Alternatives patients were put in a position to exercise some care for dependents through more frequent and closer contact with the family. When transferred to the out-patient department, their income-earning power also increased significantly. These results suggest that psychiatrically effective treatment as alternatives to hospitalization can greatly reduce the economic burden to the community of operating successful mental clinics.

Based upon the same concept of costs to the community, the five patterns of alternatives shown in Table 1 were also compared. The striking fact here is the different ranking of the patterns. Table 2 shows the total costs to the community expressed as percentages of the total cost of Pattern A and ranked in increasing sequence of cost. Also shown in Table 2 for comparison are the costs per service hour of different patterns to the health center. Patterns D and E, characterized by a predominance of in-

⁴ The occupations of the alternatives patients were recorded and the gross income per day for each occupation in the locality of employment was estimated. The gross income was adjusted for tax deductions (based on number of dependents, medical expenses not reimbursed and standard other deductions). The net loss in income per day was multiplied by the total number of days unemployed to obtain the final estimate. For patients with no remunerative employment (housewives, students, etc.), the gross income was considered to be zero, and tax deductions were attributed to the income of the head of the household. Consequently, the net loss of income from unemployment was negative in some cases. This was in all cases offset by positive costs for care of dependents in the third component.

⁵ The cost difference is statistically significant at the 5% level.

TABLE 2

Costs of different patterns of alternatives treatment

(Costs are expressed as percentages of Pattern A.)

TOTAL COST PER PATIENT TO THE COMMUNITY		COST PER SERVICE HOUR PER PATIENT TO THE HEALTH CENTER	
Pattern D	42.6	Pattern A	100.0
Pattern E	78.4	Pattern B	169.3*
Pattern C	94.3*	Pattern C	218.4*
Pattern A	100.0*	Pattern D	500.9+
Pattern B	117.1	Pattern E	535.8+

* + Not significantly different.

dividual therapy and testing, showed the highest cost per service hour because of the low ratio of patients to (highly skilled) staff. However, in the *total* cost to the community they appear to have the smallest cost. The difference between Patterns A and C, the intermediate cost patterns, are not statistically significant.

The main reasons for the low cost of Patterns D and E are three: 1) Outpatients require a smaller fixed cost of physical plant, and all patients in Patterns D and E evidence a proportionately large amount of total time as out-patients. 2) When patients were transferred from in-service or day-service to the out-patient department, their income-earning power increased substantially. 3) Correlated with the patients' increased earning was reduced cost to the community for care of dependents, which could not be achieved to nearly the same degree by temporary in-service or day-program treatment.

We may conclude that though the cost per service hour is largest for Patterns D and E, in the long run the total cost to the community is smallest. Given that all alternatives on the average show a smaller cost to the community than does hospitalization, in the case of patients for whom

individual therapy on an out-patient basis is recommended as an effective alternative to hospitalization, the costs of treatment are least.

CONCLUSION

Certain generalizations emerge from this investigation. If we assume the observations on the 42 alternatives patients and the 50 hospitalized patients comprise a random sample from a normal population, we may infer the probable "true" cost differentials for the population. The 95% confidence limits for the mean total costs in the sample were computed. With respect to the cost to the mental health center, in the long run on the average in 95 cases out of every 100, the cost of treatment according to some alternatives program will range between 49 and 80% of the cost of hospitalization. With respect to the cost to the community, it will range between 29 and 57% of the cost of hospitalization.

Significant differences in the patterns of alternatives treatment also exist. Where psychiatric effectiveness can be obtained by combinations of milieu treatment and group therapy, the cost per service hour per patient to the mental health center can be reduced. However, because of the inclusion

of income foregone and the cost of care for dependents, the ranking of total costs of different alternatives to the community differs. Treatments characterized by relatively large amounts of individual therapy on an out-patient basis show the least total cost to the community in the long run.

An economic approach to determining costs of various patterns of psychiatric treatment is feasible—and might well find more general application. The range of patterns identified with their widely ranging costs was, in a way, a remarkable finding. Although we all have a constant realization of the greater costs of one treatment procedure than another, this fact is often overlooked. When it is recognized, it is considered more as the expense of a particular treatment

rather than as a total comprehensive pattern of treatment.

Also, in out-patient treatment it is easy to overlook the immense difference between maintaining the patient as a functioning citizen in the community, even at substantial expenditure for psychotherapy, and the total burden of removing him to in-patient hospitalization.

This is in many respects a pilot project which should lead to a clearer evaluation everywhere of treatment costs in many different settings. It demonstrates a difference in cost of a variety of treatment patterns, and when thought of in terms of the private or public cost of treatment of the mentally ill, it suggests that further studies of this type will prove valuable.

KURT WOLFF, M.D.

The volunteer as a member of the psychiatric team

That the volunteer service is of great importance for the patients in mental institutions is a fact no psychiatrist or hospital administrator doubts any more. Quite a few studies have been undertaken on this subject, directed toward a more effective organization of the volunteer service.

The philosophy behind the service, however, is not always completely understood. Frequently the volunteer starts to work, not only without sufficient training for her duties, but also without the right understanding of what her service means to the hospital, to the patients and to herself. The goal to be reached, the attitude to be taken

during her service, the rationale behind the organization into which the volunteer should be fitted, and the dynamics involved, are rarely discussed. Therefore the volunteer service is often not so effective as it should be. The patients might even become more disturbed by the volunteers' attitudes, and the volunteer herself might feel unhappy, lost, and "left out."

It is a fact that some volunteers work most effectively on individual assignments. These are volunteers who have had some previous training and experience with patients and who possess special talents, such as playing an instrument, singing, doing crochet work, teaching gymnastics or dancing, or who are experts in some other recreational field. These volunteers should be considered on an individual basis and placed in assignments for which they are best fitted. Other volunteers, however, work best as a member of a psychiatric team in

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which every individual has an assignment and works harmoniously with other team members toward a common therapeutic goal. The goal might be helping an uncommunicative, shy and withdrawn schizophrenic patient to improve his interpersonal relationships or finding a therapeutic outlet for the aggressive drives of an essentially hostile and occasionally disturbed patient.

In my own experience of mental hospitals, I have found the second approach, more suitable and more effective for the majority of volunteers, and therefore this paper will deal with the team-member volunteer. Both kinds of volunteers however—the team member and the volunteer working on a more individual basis—need close supervision in the form of encouragement, advice regarding the right attitude to be taken toward the patient and the meaning and goal of the therapeutic approach. This supervision should be given by the volunteer supervisor who is responsible to the chairman of the psychiatric team, the psychiatrist.

As a member of the psychiatric team, the volunteer has to accept and understand its ideas and methods of work, and gain insight into her own possibilities and limitations. The volunteer, indeed, should acquire the feeling of belonging to the team. This team should be guided by the psychiatrist with a psychologist, a social worker, an adjunctive therapist, a psychiatric aid, and a volunteer (or a group of volunteers) as members.

From staff meetings and discussions among the members of the psychiatric team, the volunteer should learn the patients' motivations and psychological needs. Only when the volunteer is sufficiently oriented regarding the dynamics and the background of the patient and acquires some understanding about the patients' emotional dis-

turbances, will she be able to become a useful member of the psychiatric team and help to fulfill the patients' psychological needs. According to Maslow,¹ the psychological needs of a patient represent one of the greatest problems in understanding and handling the patient. When very little is known about a patient's conscious or unconscious needs and motivations, no member of the psychiatric team can be of therapeutic usefulness in helping his adjustment, or his improvement and rehabilitation. First of all it is important to find out, on an individual basis, the nature of these psychological needs and the reason why fulfillment of them was not possible before his hospitalization. Only then is the psychiatric team in a better position to help a patient, directly or indirectly, by giving him that for which he is longing. Sometimes, we might be of assistance by influencing the patient's motivations or finding outlets or sublimations for his drives.

It is well known that every individual has psychological needs. The most important and urgent ones are: the need for safety, representing a reaction to threats and danger caused frequently by assault, separations, divorce, death of a relative, by some kind of physical disability, or by unemployment and its consequences; the need to belong to a group and to be loved, the possibility to give and to receive affection and to be accepted by a group of friends or neighbors. In connection with this, there are the needs for esteem, self-respect and prestige, which for every individual have to be earned and which are dependent on the opinion of others. Furthermore, there are esthetic needs which might be a necessity for many persons who become disturbed

¹ Maslow, A. H. *Motivation and Personality*. New York, Harper & Brothers, 1954.

by merely looking at ugly things. Finally, there are the needs of self-actualization which by no means are to be underestimated. Every one of us should do that for which he is best suited and should not be forced to choose an occupation he dislikes.

Many of our patients were unable to fulfill such needs in the past, causing them to become upset, excited, irritable, negativistic, hostile or depressed and consequently in need of psychiatric treatment. Very frequently, the patient's needs are not easily understood because they are of an unconscious nature. They might be due, for instance, to feelings of guilt, to criminal thoughts or actions, or to unconscious feelings of hate toward a near relative and so have become the real cause of a psychotic depression. For many of our patients, hospitalization could have been avoided if their needs had been recognized in their previous environment and treated. Once a patient is hospitalized, however, we have to be aware of the fact that the fulfillment of these needs is a necessity. Without knowledge and fulfillment of these needs, in or outside of the hospital, the patient can't improve or find his way back to his family and to his community. If we want our patients again to become useful and happy members of their own environment, we must give them what they really need in and outside the hospital.

Therefore, the goal of the members of the psychiatric team should be that of understanding and trying to fulfill the patients' needs and helping them in their rehabilitation. The volunteer, as a member of the psychiatric team, should know a great deal about the patients' needs and motivations, and should direct her gestures, words, and actions accordingly. Every patient is an individual and has to be observed and understood separately.

Once the volunteer has learned the pa-

tients' needs, her role can be one of several. She might be assigned to a single patient or to a group of patients, in the role of a mother, a figure that the patient has missed all his life. She might be helpful in assisting a patient toward recovering his self-esteem, injured by mistakes or failures. She might help a patient to regain confidence from knowing he is liked and accepted; or she might urge him to become a member of a group and thus overcome loneliness and isolation; and finally, she might be helpful in restoring his feeling of being safe and protected. The volunteer could be very useful in showing a patient a new way toward self-actualization; she can give him support in expressing a forgotten or neglected talent—such as playing a musical instrument, singing, painting, or writing poetry.

The volunteer may befriend the patient through various means: bus rides, walking on the grounds, group singing, piano or sewing lessons, bingo playing or shopping tours. It is important, however, that the volunteer realize that the purpose of her service is a therapeutic one. Entertainment is not the therapeutic goal, but it is essential to form an interpersonal relationship based on liking of the patient, sympathy with, and real understanding of his problems. Only when such a relationship between volunteer and patient has been established can the volunteer be considered a useful member of the psychiatric team. All this can be, and should be, done by the volunteer once he or she has enough understanding of the patients' needs.

But the possibilities and responsibilities of the volunteer are not limited to service inside a hospital. The experienced volunteer may represent, with tact and sympathy, the most important and urgently wanted bridge for a patient's return to his environment and community. She might help a

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patient to readjust himself to the circle of his family, to a foster home, or to an old age home by giving him support, visiting him and continuing to show interest in him after he leaves the hospital. The volunteer can try to introduce the patient to neighbors, help him to form new friendships and find recreational activities outside the hospital, accompany him to church activities, and eventually, help him to find the right kind of employment.

Finally, the volunteer can become very useful and important to the psychiatric team by assisting in the common fight against discriminatory treatment of the mentally sick. The volunteer, knowing about

the emotional disturbance of the patient and his improvement through psychiatric treatment, can help to convince members of the community that a patient released from hospitalization can again lead a normal life.

The volunteer might become a valuable helper for the psychiatric team, indeed, by trying to make the community aware of the fact that a psychiatric patient is essentially no different from any other patient suffering from a disease which at times causes handicaps and limitations; that the mentally sick person can improve and again become a useful and accepted member of his community.

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The problem of unvisited patients in a mental hospital

It is generally conceded that the visits of relatives, except in some unusual cases, can be of considerable help in the treatment and rehabilitation of mental patients (2, 3, 4, 8). Most mental hospitals have a considerable number of patients who have not been visited by any of their relatives for many months. With the exception of an article by Sommer (9) there is little information on the magnitude of the problem, the reasons for its existence, and what might be done to alleviate it.

This study of unvisited patients was done at the VA Hospital at Fort Lyon, Colo., a 681-bed hospital for neuropsychiatric male patients. It is somewhat isolated; the nearest city of more than 10,000 people is Pueblo, about 100 miles distant. Most relatives of the patients live more than 100 miles from the hospital, and some diffi-

culties are encountered by those who must use public transportation to reach the hospital.

DISTRIBUTION AND CHARACTERISTICS OF UNVISITED PATIENTS

There were 646 patients at Fort Lyon on February 4, 1958. Of these, 263, or 41% of the total, neither had had a visitor for a year or more nor had left the hospital to visit with relatives. Of the 263, 101 patients, or 16% of all the patients, had never had a visit since the start of their hospitalization. Several had not had a visit for 25 years.

One characteristic of the unvisited patients was their significantly greater age than the visited patients. The median age of all hospital patients as of November 12, 1957, was 46 years, whereas the median age of the unvisited patients was 61 years. It was found that 65% of all patients above the age of 60 were among the unvisited patients.

From a strictly statistical standpoint, the

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TABLE 1

Age of unvisited patients as compared by age group with the total hospital population¹

AGE GROUP	NUMBER OF PATIENTS IN AGE GROUP	PERCENTAGE OF HOSPITAL POPULATION	NUMBER OF UNVISITED PATIENTS IN AGE GROUP	PERCENTAGE OF TOTAL UNVISITED PATIENTS IN AGE GROUP
20-29	50	7.6	5	1.9
30-39	213	32.2	35	13.3
40-49	109	16.4	27	10.3
50-59	44	6.7	36	13.7
60-	245	37.1	160	60.8
Total	661	100.0	263	100.0

$X^2 = 46.3$ $df = 4$ $p < .001$

percentage of unvisited patients in an age group should be about the same as the percentage of all hospitalized patients in that certain age group. In the first three age groups, up to age 49, there was a lower percentage of unvisited patients than for the total hospital population. In the last two groups, particularly the 60 and older group, there was a higher percentage of unvisited patients than for the total population.

The average length of hospitalization of all unvisited patients was 14.7 years whereas the same average for all patients (as obtained from a 20% sample of the hospital in November 1958) was 9.9 years. The length of hospitalization of unvisited patients was significantly greater ($p < .001$) than for the total population. These findings tend to agree with Archese (1) and Sommer (9) who found the longer the length of hospitalization, the fewer visits there were. Both authors maintained that length of hospitalization had a closer relationship to frequency of visits than did the patients' ages.²

A surprisingly large percentage of the unvisited patients (58%) had never been mar-

ried.³ According to the 1950 Census (10) only 14.4% of males 20 years of age or over in the United States are single. Also, 50% of the few married patients in the unvisited group were divorced or widowers. The case records suggest that these divorced men were usually given up by their wives when it became clear that their husbands had a poor possibility of taking up a productive life again.

Every patient admitted to a VA Hospital has entered in his record the name of a per-

¹ As of November 12, 1957.

² Sommer found that the age of patients had no relation to whether a patient was receiving visits and that there was not a direct relationship between the age of patients and their lengths of hospitalization. Our findings do not agree on this point. For a ward studied at Fort Lyon patients' ages correlated .66 ($p < .001$) with their lengths of hospitalization.

³ The Psychiatric Evaluation Project's preliminary findings (7) indicate all VA mental hospitals have a high proportion of unmarried patients. Seemingly this is due, among other things, to married patients, as a group, leaving the hospital sooner and staying out longer.

son to be notified in an emergency, who is called "next of kin." The 263 unvisited patients list the following next of kin: siblings for 49.8%; parents for only 14.4%; wives and children for even less (12.5%); other relatives are listed for the remaining patients, except for eight having no known kin. As 61% of the unvisited patients are over 60 years old, not many could be expected to have living parents. Since the majority of these patients had never been married and most of those who had been were now divorced or widowers, it is clear why few wives or children were listed. The young patients tended to list parents as next of kin and the patients over 40 usually listed siblings.

Our data seem to indicate that the farther a relative lives from the hospital, the less likely he or she is to visit. Of 101 patients never receiving a visit at Fort Lyon, only 21% had listed relatives in Colorado. On one ward it was found that 47% of patients never having a visit had relatives living more than 500 miles from the hospital, while only 15% of patients having visits during the year had relatives living more than 500 miles away. Thus there seemed to be a lower frequency of visits where the listed relative lived outside the State of Colorado or more than 500 miles from the hospital.⁴

Practically all of the unvisited patients would be considered chronic, rather than acute, patients. Also 77% of them were diagnosed as having a functional psychosis, which was not a significantly different percentage from the hospital population as a

whole. There was a slightly higher percentage of patients with organic brain impairment among unvisited patients than in the whole population, probably due to the greater average age of the former group. It made no difference in the chances of being unvisited whether or not the patient was of Spanish-American origin.

If a patient is adjudged to have a disability incurred during his service duties, he is called "service-connected" and usually receives compensation. There was a smaller number ($p < .01$) of service-connected patients among the unvisited. The receiving of compensation may tend to encourage the visits of some relatives. The effect of patients' service-connection may be exaggerated here as there were less service-connected among the older patients, and it has already been demonstrated age was definitely related to the lack of visits by relatives.

Each patient in the hospital had his behavior rated in 11 different areas using the L-M Fergus Falls Behavior Rating Scale.⁵ Each area was rated from 1 (worst) to 5 (best) by the aide who knew the patient best. A patient's ratings in each of the 11 measured areas of behavior were added and then divided by 11 to give an average behavioral score for that patient. The mean of these average behavior scores on all patients was 3.03. The mean for patients receiving visits was 3.15; for those unvisited for one year it was 2.84, and for those never receiving visits it was 2.77. The distribution of behavior ratings among the visited and unvisited patients was significantly different from chance ($p < .001$). Inspection of our data shows that the visited patients tended to receive higher behavior ratings, while the patients in the two unvisited groups had lower behavior ratings.

One ward (Upper 8) was studied in more detail. The visited patients on this ward

⁴ Neither Archese (1) nor Summer (9) found that distance of residence from the hospital was related to frequency of visits to patients. However, the distances involved are not as great as at this hospital.

⁵ The scale is too long to be given in this article. For a copy of the scale, details of its use, and normative data see *Psychological Monographs* No. 441 (5).

tended to score better than the unvisited ones in the three behavior areas of response to meals, attention to dress and person, and attitude toward work. It is of interest that no unvisited patient on Upper 8 had even a fairly good attitude toward work.

EFFECT OF VARIOUS KINDS OF LETTERS IN INDUCING VISITS

As 41% of the patients in the hospital had not been visited by their relatives for at least one year, we wondered what could be done to improve the situation. Considering the shortage of hospital staff and of travel money, it seemed the best way to contact the relatives was by letter. What effect would letters have in securing replies and in motivating visits? Would simple variations of letters cause differences in response?

The usual type of letter to a patient's relative is "patient-centered;" it stresses the importance of the relative visiting in terms of its value to the patient. We wanted to know if a letter indicating an interest by the hospital in problems the relative might have because of the patient's illness would be more effective in stimulating a visit. To investigate this matter, three different kinds of letters were composed to send to relatives. The kinds of letters were as follows: 1) a "patient-centered" letter emphasizing the value of a visit to the patient; 2) a "relative-centered" letter indicating that a social worker would be interested in discussing any problems, and 3) a similar letter referring to emotional problems the relative might have because of the patient's hospitalization. The letters were short and all letters of one kind were alike except for appropriate changes to fit the chosen relative.⁶

The subjects for this investigation were the 112 unvisited patients who had relatives living within 500 miles of the hospital. These 112 patients were divided into four

groups with the patients equated as far as possible as to age, length of hospitalization, behavioral adjustment, length of time since last visit, and relationship of relative. The selected relative of each patient in the first group was sent a "patient-centered" letter; relatives of the second group were sent a "relative-centered, any problem" letter; and relatives of the third group were sent a "relative-centered, emotional problem" letter. Only one relative was written for each patient. The fourth group of patients was a control and no letters were sent to their relatives.

Responses to the three different types of letters were evaluated in terms of replies or visits within three months after the mailing date. During this time, there were 13 visits and 21 replies by the selected relatives distributed as shown in Table 2.

The number of visits resulting from the letters was discouragingly small. None of the three types of letters was successful in inducing significantly more visits than were received by the control group. The patient-centered letters brought significantly more replies than the two types of relative-centered letters combined. Also there were more answers ($p < .02$) to the patient-centered letters than there were letters from relatives of the control group. One may conclude that the conventional patient-centered letters are more effective in securing replies than the relative-centered letters used in this study.

ATTITUDES OF PATIENTS AND THEIR RELATIVES CONCERNING HOSPITAL VISITS

With a few exceptions, all patients whose relatives were sent letters were interviewed

⁶ Samples of the three kinds of letters can be obtained by writing the authors.

TABLE 2

Response to different types of letters within three months

GROUP	NO. OF VISITS	NO. OF LETTERS FROM RELATIVES	VISITS AND ANSWERS COMBINED
Patient-centered	5	12	3
Relative-centered, any problem	5	3	2
Relative-centered, emotional problem	3	6	2
Control ⁷	4	4	0

individually. They were asked, "What do you think is the reason your relatives have not been visiting you?" Twenty-seven percent of those interviewed did not give a recognizable answer, chiefly because of muteness, suspicion, or hostility. Another 18% gave inappropriate responses, such as "I don't have a relative" (when they actually did). The responses often showed some hostility to relatives who had failed to visit. For example, one patient said, "They have not come to see me for so long, I don't know if I have any relatives." About 17% of the patients said the relatives didn't visit because "they are too busy with other things" or "they are not interested in me." Another 13% said they did not know why relatives failed to visit them. The balance of the responses can be classified as follows: Lack of money and difficulty of the relatives in finding transportation or a place to stay, 11%; the relative was too old or sick, 9%; relative lived too far away, 4%; one patient believed correctly that his nearest of kin was afraid of him.

Not all of the unvisited patients wanted a visit. About 44% of the interviewed patients indicated interest in having a relative visit them, 20% were indifferent, 15% said

they did not want a visit, and the remaining 21% were unratable. Some of these unratables were hostile to the hospital and to other patients and probably would be to their relatives. There was the distinct possibility that the indifference of some patients was a mask being used to hide their feelings of rejection. While the unvisited patients are not a particularly attractive or responsive group, their behavior alone cannot explain the lack of visits to them. Judging from the evaluative interviews, over half of the unvisited patients should manifest behavior reasonably acceptable to a visiting relative.

The thirteen relatives of patients in the experimental groups who visited were interviewed individually. Nine of them gave more than one reason for their failure to visit. Most frequently given reason was the long distance to the hospital making transportation difficult to arrange. Other reasons in order of frequency were sickness in the family or other pressing family obligation, the relative's advanced age making travel difficult, lack of time, the patient's regressed condition at the previous visit, and lack of money.

The reasons given for not visiting did have some validity. These 13 visitors travelled an average distance of 315 miles one way to reach the hospital and some underwent considerable inconvenience.

⁷ The figures shown for the control group are based on letters and visits from relatives who would have been written if the particular control patient had been assigned to an experimental group.

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Five of the relatives (four mothers and one wife) indicated they had little or no surplus funds after meeting their living expenses and thus the visit caused financial hardship. Only 15 of the 85 letters were to parents, yet 7 of the 13 hospital visits were by parents. The average age of these parents was 67, so the advanced age of relatives could make visits difficult in some cases.

The average time since these 13 unvisited patients had had a visit was two years and two months. Several relatives indicated they felt guilty for not visiting more frequently, but a few were not at all defensive concerning their failure to visit. After the visits, eight relatives believed the visited patients had little or no interest in having such a visit. Five patients expressed interest in the visits and two of these asked to be taken home.

Ten of the 13 visitors said the patient's condition had nothing to do with their infrequent visits. Of the remaining three, a mother said her son was "indifferent" about her visits and it caused her to have an "emotional reaction," which she blamed on guilt feelings over her part in causing the son's illness. A wife did not visit because she thought her absence would help her husband overcome his paranoid delusions about her. The third, a mother, believed her visits upset the patient as they seemed to increase his demands to be taken home, although this was not advisable for psychiatric reasons.

Unvisited patients and their relatives seldom corresponded. Of the patients answering questions, 69% said they received letters infrequently or never. A considerable number of these patients did receive gift packages, particularly at Christmas. The thirteen visitors, speaking of the patients related to them, said four of the patients did not write, six wrote infrequently, two occasionally, and one frequently.

Although all letters sent to relatives stated a social worker would be interested in talking to the relative when he or she visited, it is believed not one of the 13 visitors asked to see a social worker. The receptionist, after checking her lists, informed the visiting relatives a social worker wished to see them. It might have been that eventually some relatives would have asked to see the social worker without being reminded.

DISCUSSION

Studies of unvisited patients raise the question of what is cause and what is effect. For example, are patients unvisited because they showed regressed behavior, or is such behavior the result of deterioration from the lack of visits by relatives, as well as the lack of other stimulation found outside the hospital? Our impression is that there is a subtle interplay of forces we are unable to separate at present.

The experience of the social workers at this hospital is that short, impersonal letters will not motivate many visits to chronic patients although such letters will often result in visits to newly admitted patients. In planning the letters sent to relatives in this study, one psychiatrist reasoned that most hospital letters are concerned only with the patient. Relatives, like all of us, are mostly concerned with themselves and their own problems. Therefore, to get visits to the hospital, one should write letters recognizing the relative's problems and offering to discuss them. This proved incorrect. One reason for this may be that most relatives of Fort Lyon patients are of the lower or lower-middle class. Hollingshead and Redlich (6) have pointed out that these classes as a group are resistant to psychotherapy, see little value in talking about problems, and tend to think and talk in organic rather than in psychodynamic terms. Letters in

this study suggesting the relatives might have problems arising from the patients' hospitalization may have aroused resistance in the relatives by suggesting that "something is wrong" with the relatives. Better educated and more economically secure relatives might be more receptive to discussing their own problems.

We formed the impression that there is a definite reluctance on the part of most relatives to visit a chronic patient. After the patient has been in the hospital for some years, his family establishes an adjustment without him. Frequently the relatives and their neighbors find this new situation less anxiety-producing than the condition prevailing when the patient was at home. The relatives tend to think their family would be safer and happier if the patient were "written off." They rationalize that the patient is getting better care in the hospital. This whole situation is more fully described in *Closed Ranks* by Elaine and John Cumming (3). Our experience also indicates that relatives are often reluctant to see professional personnel because they are afraid that they will be blamed for helping to cause the patient's illness and leaving him in the hospital; they may be "talked into" taking this unwanted, problem-arousing patient back into their family group. This is a description of typical conditions and no attempt will be made here to blame or excuse relatives' behavior.

We should not be intemperate in criticizing all relatives for not visiting or for failing to take the patient home. Our patients are our primary concern and we tend to forget the interests of the relatives. It is only natural that the relatives would think in terms of the greatest good for the greatest number of family members.⁸ The patient in the home may be a questionable example to children, a financial drain, a person to be waited on, a disrupter of routine, or a source

of anxiety or friction. There is frequently some truth in the relative's statement that "I can't keep him in my home because it would be unfair to others." This argument can be used as a rationalization for relatives refusing to take any responsibility.

Our changing culture has made three other factors important in the attempt to secure more interaction between the patient and his relatives. One factor is that the mobility of American families in recent times means that after a few years of hospitalization, the patient often finds his relatives are scattered and some will no longer be within reasonable visiting distance. Secondly, there is a growing feeling that as a taxpayer one is entitled to have mentally sick or aged relatives cared for by a governmental agency, which can supposedly render more efficient care. Usually this is overtly accepted but with such guilt as to render visits anxiety-provoking to the relatives. Thirdly, the structure of the American family has changed. It is now smaller and usually does not have an adult in the home at all times to supervise a mentally ill relative.^{9, 10}

One visit of a relative to a patient may help by leading to renewed interest, greater understanding, or a trial stay at home. However, positive results usually require frequent visits. Therefore, it becomes a question of values. For example, when one considers persuading an aged parent on limited income to travel several hundred miles to see what seems to be a withdrawn

⁸ Hollingshead, August B., "Class Differences in Family Stability," *Social Perspectives on Behavior*, edited by Stein, H. D., and R. A. Cloward. Glencoe, Ill., Free Press, 1958.

⁹ Hollingshead, August B., *op. cit.*

¹⁰ Woods, Frances J., "Cultural Conditioning and Mental Health," *Social Casework*, 39(June 1958), 327-33.

and unappreciative patient, will the probable result to the patient be worth the sacrifice of the parent?

What can be suggested to alleviate this situation of unvisited patients? First, there should be greater emphasis on getting the patient out of the hospital before family contacts are broken and he loses his desire to live outside the hospital. Secondly, relatives should be helped to feel their visits are welcome, satisfactory, and useful. Thirdly, we should realize that some patients are becoming chronic hospital cases while hospital personnel wait for unwilling relatives with other allegedly pressing responsibilities to take the patients, so there should be earlier resort to such measures as foster homes and night hospitals.

CONCLUSIONS

1. At a somewhat isolated mental hospital, 41% of the patients had not had a visitor within the last year and 16% had not had a visit since hospitalization. Several had no visit for 25 years.
2. Unvisited patients, as compared with the total hospital population, tended to be characterized by the following indices: older, hospitalized longer, never married, no service-connected compensation, parents not living, no relatives residing within 500 miles of the hospital, classified as chronically ill, and displaying more atypical behavior.
3. Patient-centered letters brought significantly more replies, but there was no difference in the resulting number of visits. All letters used did poorly in obtaining visits to patients.
4. Patients thought they were not being visited because relatives were too busy, not interested, lacked money, were sick, or lived too far away. The relatives gave the following reasons, in order of frequency, for not

visiting: distance and transportation difficulties, sickness in family or other family obligation, advanced age, lack of time, the patient's regressed and unresponsive condition, and lack of money. Twenty percent of the unvisited patients were indifferent about having a visit and 15% more did not want visitors.

5. Relatives of unvisited patients displayed a reluctance to discuss the patient with professional personnel. It was postulated that relatives of chronic patients often make a family adjustment based on the patient being in the hospital and consider it less anxiety-producing to leave the patient there.

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Survey of a group of mentally ill new immigrants placed in private institutions

We are witnessing the development of a new era in the care of mentally ill patients. The trend is to abolish the old approach of the permanent isolation of the patient—to protect society from “danger,” to relieve the family of his care, and to do little for the patient himself. Rehabilitation, with its classical definition of restoring the patient’s physical, social and mental status to that of complete usefulness, has become the goal and modern approach in the care of this large group of patients.

Society is being taught to change its attitude of repugnance towards the mentally ill and to accept them back into the community, after treatment and cure, as citizens entitled to live and work and be happy. It

is obvious that many obstacles will have to be overcome before society’s attitude changes; and health education can be one of the vital elements in helping to effect this change.

The purpose of this paper is to describe a survey made in Israel of a group of mental patients whom we were forced to hospitalize in private institutions in the early years after the establishment of the state due to a complete lack of other resources. It is our intention to stress the harmful effects of institutionalizing mentally ill patients for the sole purpose of protecting society rather than that of helping the patient to recover.

MENTAL HEALTH SERVICES IN ISRAEL

It is well known that, with the establishment of the state, Israel had to accept a mass immigration that was unselected and which brought to the country thousands of

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sick patients, including patients with mental disorders or persons who potentially would become such patients when faced with the difficulties of creating a new life in a new country.

The limited resources, lack of psychiatrists and other professional staff, as well as little experience with problems of rehabilitation, all forced the government authorities and the voluntary agencies to reduce the pressure on hospital facilities for mental patients by placing them in private institutions which, unfortunately, in many instances were sub-standard.

All during the first decade of Israel's independence, mental health services were constantly being improved and expanded—more adequate hospital beds created, mental hygiene clinics set up, better equipped staff appointed, and so on. A comprehensive rehabilitation program was introduced in the hospitals with all the necessary facilities. Special working villages, attached to hospitals, were created as an important link in the rehabilitation of mental patients. In an attempt to follow the modern concept of bringing the care of the mentally ill closer to general medical care, a psychiatric ward was installed in one big government general hospital, and another one is to be opened shortly in another general hospital. By 1958 the number of hospital beds available for the mentally ill reached the proportion of 2.14 per 1000 population compared with 1.32 in 1949.

The Ministry of Health, with the substantial economic aid of our voluntary agency, Malben-JDC (the organization set up by the American Joint Distribution Committee¹ in the early days of the State to help the government care for the needy sick, handicapped and aged new immigrants) is planning to modernize and expand the country's psychiatric services guided by the new concepts of mental hy-

giene, in which *prevention* takes the leading role. Progress has been made in this program, but nevertheless 1000 beds in private institutions are still occupied by mental patients sent to them during the earlier big waves of immigration.

To undertake the progressive transfer of these patients to government hospitals and rehabilitation facilities, or their eventual discharge, an initial study was made, by the Ministry of Health and Malben-JDC, of a group of 74 new immigrant patients who had been placed in private institutions between 1948 and 1954.

The purpose of the study was:

1. To appraise the physical, mental and social conditions of the patients.
2. To review the services presently afforded them.
3. To assess their therapeutic and social needs, and the possibilities of their rehabilitation.
4. To recommend disposal of the patients according to the services required.
5. To appraise the ability of the present institutions to care for this type of patient.

METHOD

A combined Ministry of Health and Malben-JDC team was appointed, consisting of a public health physician, a public health nurse, a psychiatrist, and a psychiatric social worker.

The team visited all the institutions in which the patients were staying, interviewed the staff of each, conducted a psychiatric examination of the patients, and surveyed the services and physical facilities of the institutions.

¹ The A.J.D.C. receives its funds in America through the United States Jewish Appeal.

A questionnaire was elaborated which, when filled out, contained all the details required for the abovementioned purpose.

ORGANIZATION

The team visited the institutions on a weekly schedule. Each institution, had been informed of the date of the visit in advance; and in each the team met with the staff, including the attending physician, and examined the patients, recording the data required by the questionnaire. As the work was completed, the team independently summarized its recommendations concerning the individual patients and the institutions.

APPRAISAL OF THE INSTITUTIONS SURVEYED

a) *Physical conditions:* In almost all the institutions the physical conditions are bad—unsuitable buildings, lack of grounds and space for recreation, overcrowding, poor equipment and sanitation. In some, considerable improvements have been made. The institution usually gives an extremely "closed-in" impression, isolating the patients from the outside world.

b) *Staffing:* There is a striking shortage of professional and other personnel. Psychiatric leadership is entirely missing, and there is no cooperation among the various members of the staff. The lack of social workers, psychologists and graduate nurses must be particularly stressed. Occupational

therapists were found in many of the institutions, but few of them were qualified. The actual staff consisted mainly of unskilled practical attendants, frequently relatives of the manager.

c) *Services:* Services which should meet the needs of the patients are either very poor or not available at all. No diagnostic facilities exist, and treatment is no more than symptomatic. The function of the nursing staff is not defined, and there is no qualified nursing supervision. Occupational therapy consists of sporadic, unplanned activities which do not take into consideration the special needs and potentialities of the patient; rather, it is designed to keep him partially occupied.

d) *General therapeutic atmosphere:* The atmosphere is of an entirely closed institution, and the isolation of the patients is strongly felt. Because of shortage and poor quality of staff, contacts are not used for creating a therapeutic atmosphere. Community feeling, interpersonal relationships and recreational atmosphere are not developed.

ANALYSIS OF THE GROUP OF PATIENTS SURVEYED

This table indicates there are more women than men in the group; and more than 80% of the patients are in the productive age group between 21 and 50.

We see that among the group surveyed 70% are Europeans, and the remaining

TABLE 1

Number of patients by age and sex

	18-20	21-30	31-40	41-50	51-60	61-70	70-	TOTAL
Males	1	9	11	5	3	1		31
Females	1	8	15	11	3	2	3	43
Total	2	17	26	16	6	3	4	74

TABLE 2

Number of patients by continent of origin and year of immigration

	1948	1949	1950	1951	TOTAL
Europe	17	20	10	5	52
Asia	2	11	7	-	20
Africa	-	1	-	-	1
South America	-	-	-	1	1
Total	19	32	17	6	74

TABLE 3

Patients by diagnostic (psychiatric) groups

DIAGNOSIS	NO. PATIENTS	TOTAL
Psychosis:		
Schizophrenia Acute	-	
Schizophrenia Chronic:		
with/without minimal impairment	7	
with moderate impairment	11	
with severe impairment	18	
Circular	2	38
Mental Deficiency Syndromes:		
A) Without evidence of brain tissue function impairment:		
Oligophrenia	3	
B) Due to or associated with impairment of brain tissue function:		
1) Congenital or developed in early childhood: Severely impaired	15	
Associated with psychotic manifestations	12	
2) Developed in later life:		
Senile or arteriosclerotic disease	5	
Associated with Lues of CNS (OPA)	1	36
Total		74

TABLE 4

Presumed length of illness

DURATION	NO. PATIENTS
Congenital	14
Since early childhood	3
6-10 years	12
10-15 years	13
15-20 years	7
20-25 years	5
Unknown	20
Total	74

30% are of Oriental origin; and that most of the patients arrived in Israel during the first three years of mass immigration.

Table 3 shows that more than 50% of the patients are psychotics, and among them a high percentage at present is in a state of severe impairment. As to the group suffering from mental deficiency syndromes, the lack of sufficient anamnestic data did not permit us to undertake any etiological diagnostic differentiation (prenatal or constitutional influences, birth-trauma, infectious diseases, intoxications, etc.). The subgroup B) includes idiots and imbeciles with or without physical disabilities (epilepsy, cerebral palsy, etc.).

As to the length of illness, our data can be presumed in only about 73% of the cases; for the remaining 27% there is no data available at all, due to the lack of the most essential social and anamnestic information.

Table 5 shows that 57 patients (or 74%) were admitted to the surveyed institutions without having been assessed before in hospitals and, according to the data we collected, such an assessment had been necessary for 36 patients out of this group of 57. The assessment, of necessity, was reduced to a symptomatic diagnosis, and was done on the basis of an interview with the psychia-

TABLE 5

Source of admission to surveyed institutions

SOURCE	NO. PATIENTS
Immigrant Camps	20
Home	17
Private institutions	18
General hospitals	2
Public mental hospitals (Kupat Cholim) ²	11
Government mental hospitals	6
Total	74

² Sick Fund of the Labor Federation of Israel (Histadrut).

trist alone; it did not represent the result of concerted activities of the staff of the ward.

Therefore the treatment was also reduced to a symptomatic one, when there was any treatment given at all.

Evaluating the need for biological treatment, we took into consideration correlation of the following data: onset of the disease, date of hospitalization, diagnosis on admission, diagnosis at present, symptomatology on admission, symptomatology at present, and information about therapies given in the past.

The patients considered here are mainly psychotics, mentally deficient with psychotic

manifestations, and those suffering from the demential syndromes. Despite the fact that the majority of the patients were in a chronic stage of the disease, their state after arrival in Israel was such as to justify biological treatment.

Half of the group of 34 patients who received adequate treatment were placed in a mental hospital (government or voluntary) before their admission to the private institution. Table 6 also shows that 10 patients out of the 54 were completely neglected, the needed treatment not being given at all. A total of 37% received poor or no treatment.

Results of treatment, symptomatic or otherwise, appear to have been extremely poor, as can be seen from Table 7 below, considering the duration of the patients' hospitalization since their arrival in the country.

Table 7 indicates that the majority of the patients had been hospitalized between seven and nine years.

This can be considered not only a result of the lack of adequate assessment possibilities, but also an indication of the impossibility of creating favorable conditions for the mentally ill because of the low qualifica-

TABLE 6

Patients in need of biological treatment

NO. REQUIRING TREATMENT	TREATMENT GIVEN		
	ADEQUATE	POOR	NEGLECTED
54	34	10	10

TABLE 7

Presumable duration of hospitalization in Israel

DURATION	NO. PATIENTS
2-3 years	1
5-6 "	3
7-8 "	40
8-9 "	24
9-10 "	3
Unknown	3
Total	74

TABLE 8

Family and patient

With Family	58	CONTACTS			TOTAL
		<i>Stable</i>	<i>Poor</i>	<i>None</i>	
Parents		13	6	1	
Wife-husband		1	2	—	
Children		6	—	2	
Brother-sister		10	11	1	
Other relatives		2	2	1	
		32	21	5	58
Without family	8				
Unknown	8				74

tion of the staff. It must not be forgotten that the attitude of the unskilled staff member towards the mentally ill is often no different from that of the general public. It is more like that of a guardian who reacts in a personal manner to the disturbed behavior of the sick without having the slightest insight as to the kind of interrelationships at play.

If to this disadvantage one adds the fact that in this survey we found no signs of integrated and directed activities of staff members, no planned individual or group approach, no planned work activities, indifference on the part of the institutions as to the necessity of keeping the patient in live contact with the outside world (see Table 8), we can state quite definitely that no planning at all was made towards rehabilitation.

In giving our recommendations for the

disposal of patients, we took into consideration primarily the needs of the patients, realizing that despite the consequences of the inadequate treatment given until now, much could still be done. The disposal of the patients was based on the actual clinical state of the patient, and on the data available as to degree of socialization, vocational training and social status.

Thus, three main groups could be differentiated: The first group, 30%, for whom rehabilitation plans could be considered; the second group, 50%, who required a long-stay annex; and the third group, 20%, requiring special care and special institutions.

The first group is composed of psychotics still in the active stage of the disease; of psychotics moderately defective, more or less compensated and still capable of achieving a higher degree of socialization; of mental defectives with mild impairment;

TABLE 9

Disposal of patients

FROM PRIVATE INSTITUTIONS TO:	HOME	FAMILY CARE	WORKING VILLAGE	MENTAL HOSP.	LONGSTAY ANNEX	SPECIAL INSTITU.	TOTAL
	1	2	10	9	36	16	74

and of some disturbed aged who could benefit from biological treatment.

We considered further stay in the surveyed institutions pointless and suggested their transfer to mental hospitals (for observation, re-evaluation, treatment), working villages (for further occupational therapy or vocational training), for family care and/or discharge home, according to their needs and the family situation.

The second group is composed of chronic deteriorated psychotics with or without original mental defect and of some demential patients. The mental condition of the patients belonging to this group does not permit us, at present, to establish any therapeutical (medical) program for them. These patients are classified as in need of care in a longstay annex. By this term we designate an institution which has facilities for patients who do not require constant medical and nursing care, but merely supervision. Such facilities should be affiliated with a well-equipped mental hospital; and a two-way shifting of patients (between hospital and longstay annex) should be possible at all times, according to the needs of the patients.

The third group is composed of mentally defective patients with evidence of impairment of brain tissue function, suffered congenitally or since early childhood. This group includes some physically handicapped (epileptics, cerebral palsied, etc.). The patients are classified as belonging to special institutions. The treatment in such institutions should consist of the elimination, insofar as possible, of concomitant physical factors (such as epilepsy, metabolic disorders, vitamin deficiencies, spastic disorders, etc.). The institutions should be able to provide the proper selective environment, protection from failure or exploitation, and utilization of special talents to the best advantage of the patient and of society.

Finally, it seems necessary to add that in our disposal we did not take into consideration the aged mentally disturbed as belonging to a special group suited to special institutions. The reason for this is that a relatively small number of the patients surveyed belong to this category. These elderly patients were classified as belonging to a longstay annex or a mental hospital, according to their clinical state.

DISCUSSION

Most of the mental patients surveyed are young persons without somatic diseases and with a long life expectancy. If, after this prolonged institutionalization (seven to nine years and more) we were still able to consider 30% as being good prospects for rehabilitation and final discharge, we can certainly suppose that the percentage who could have gained from the new approach in treatment and care of the mentally ill might have been much higher. This would have meant more lives saved and families restored.

The forced placement, due to special circumstances, of mental patients in private institutions of substandard quality may have protected the public from the disturbed person, but it lowered the health status of the patient, furthered his mental deterioration, completely isolated him from his family and from society, and transformed him into a permanent institutionalized patient with a hopeless life ahead of him.

We thought it would be interesting to reveal our findings, which prove again how wrong is the concept of the asylum and how much we must strive towards development of a modern program in mental health.

SUMMARY

A brief discussion of the modern concepts of care and rehabilitation for patients with

mental disorders, and the development of modern mental hygiene services in Israel, forms the background for this report of a survey, conducted by Israel's Ministry of Health and Malben-JDC, of a group of mental patients placed in private institutions.

In the light of modern psychiatry, the unsuitable environment of the asylum-like private institution was underlined, and the neglect of the patient in order to "protect the public" was stressed.

The findings of the survey show the urgent need to continue with the development of a modern psychiatric service in Israel.

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Individual actualization in complex organizations

Recently the writer completed the first phase of a research project having two objectives. The first is to provide knowledge concerning mental health problems in industrial organizations; more specifically, with understanding the difficulties the individual faces and the opportunities he has for self-actualization in complex organizations. The second objective is to test parts of a theoretical framework about human problems of complex organizations and is reported in detail elsewhere (1). The purpose of this paper is to present some recent results which may alter some commonly accepted notions of individual self-actualization in complex organizations.

Mr. Argyris is an associate professor in the department of industrial administration at Yale University. The research project described in this article is being supported with a grant from the National Institute of Mental Health.

Although the research to be discussed is being conducted in an industrial organization, the theory and the results are believed to apply to other kinds of complex organizations (for instance, hospitals, schools, banks, government agencies). Therefore, although the terms "management" and "employee" will be used, it is assumed that the results apply to any (genotypically) similar relationship between any administrator and employees.

THEORETICAL FRAMEWORK

Since discussions of the theoretical framework and the many studies from which it is evolved are available in other publications (1, 2) only some of the main propositions are defined in order to give the reader an acquaintance with the theoretical foundations of the research. The most relevant propositions follow:

● Personality is conceptualized as a) being an organization of parts in which the parts maintain the whole and the whole maintains the parts; b) seeking internal balance (usually called adjustment) and external balance (usually called adaptation); c) being propelled by psychological as well as physical energy; d) located in the need systems; and e) expressed through the abilities. f) The personality organization may be called "the self" which g) acts to color all the individual's experiences, thereby causing him to live in "private worlds," and which h) is capable of defending or maintaining itself against threats of all types.

● The development of the human personality can be hypothesized to follow the directions and dimensions outlined in the following model. It is assumed that human beings in our culture:

a) Tend to develop from a state of passivity as infants to a state of increasing activity as adults. (This is what Erikson (3) has called self-initiative and Bronfenbrenner (4) has called self-determination.)

b) Tend to develop from a state of dependence upon others as infants to a state of relative independence as adults. Relative independence is the ability to "stand on one's own two feet" and simultaneously to acknowledge healthy dependencies.¹ It is characterized by the liberation of the individual from his childhood determiners of behavior (for example, his family) and his development of his own set of behavioral determiners. The mature individual does not tend to react to others (for example, the boss) in terms of patterns learned during childhood.²

c) Tend to develop from being capable of behaving only in a few ways as an infant to being capable of behaving in many different ways as an adult.³

d) Tend to develop from having erratic, casual, shallow, quickly-dropped interests as an infant to having deeper interests as an adult. The mature state is characterized by an endless series of challenges; and the reward comes from doing something for its own sake. The tendency is to analyze and study phenomena in their full-blown wholeness, complexity and depth.⁴

e) Tend to develop from having a short time perspective (that is, one in which the present largely determines behavior) as an infant, to a much longer time perspective as an adult (that is, one in which the behavior is more affected by the past and the future⁵). Bakke cogently describes the importance of time perspective in the lives of workers and their families and the variety of foresight practices by means of which they seek to secure the future (5).

f) Tend to develop from being in a subordinate position in the family and society as an infant to aspiring to occupy an equal

¹ This is similar to Erikson's "sense of autonomy" and Bronfenbrenner's "state of creative interdependence."

² White, Robert W., *Lives in Progress*. New York, Dryden Press, 1952.

³ Lewin and Kounin believe that as the individual develops needs and abilities the boundaries between them become more rigid. This explains why an adult is better able than a child to be frustrated in one activity and still behave constructively in another. See Lewin, Kurt, *A Dynamic Theory of Personality*, New York, McGraw-Hill Book Co., 1935, and Kounin, Jacob S., "Intellectual Development and Rigidity," *Child Behavior and Development*, edited by R. Barker, J. Kounin, and H. R. Wright. New York, McGraw-Hill Book Co., 1943, 179-198.

⁴ White, Robert W., *op. cit.*, pp. 347 ff.

⁵ Lewin also cites the billions of dollars that are invested in insurance policies. See Lewin, Kurt, "Time Perspective and Morale," *Resolving Social Conflicts*. New York, Harper & Brothers, 1958, p. 105.

and/or superordinate position relative to their peers.

g) Tend to develop from a lack of awareness of self as an infant to an awareness of and control over self as an adult. The adult who tends to experience adequate and successful control over his own behavior tends to develop a sense of integrity (Erikson) and feelings of self-worth.⁶ Bakke (6, 7) shows that one of the most important needs of workers is to enlarge those areas of their lives in which their own decisions determine the outcome of their efforts.

- Most human problems in organizations arise because relatively healthy people in our culture are asked to participate in work situations which coerce them to be dependent, subordinate, submissive, to use few of their more than *skin-surface* abilities.

- There are three major sets of variables which cause the dependence and subordination. The formal organization structure is the first variable. (This includes the technology.) Directive leadership is the second, and managerial control (budget, incentive systems, quality control, motion and time studies) is the third.

- The degree of dependence and subordination that these three variables cause tends to increase as one goes down the chain of command, and the lower echelons of the organization take on the characteristics of mass-production.

- Healthy human beings (in our culture) tend to find dependence, subordination and submissiveness frustrating. They would prefer to be relatively independent, to be active, to use many of their deeper abilities; and

they aspire to positions equal with or higher than their peers. Frustration leads to regression, aggression, and tension. These in turn lead to conflict. (The individual prefers to leave but fears doing so.) Moreover, it can be shown that under these conditions, the individual will tend to experience psychological failure and short time perspective.

- Individuals will adapt to the frustration, conflict, failure, and short time perspective by creating any one or a combination of the following *informal* activities.

- a) Leave the situation (absenteeism and turnover).

- b) Climb the organizational ladder.

- c) Become defensive (daydream, become aggressive, nurture grievances, regress, project, feel a low sense of self-worth).

- d) Become apathetic, disinterested, non-ego involved in the organization and its formal goals.

- e) Create informal groups to sanction the defense reactions in c) and d).

- f) Formalize the informal groups in the form of the trade unions.

- g) De-emphasize in their own minds the importance of self-growth and creativity, and emphasize the importance of money and other material rewards.

- h) Accept the above described ways of behaving as being proper for their lives outside the organization.

- Management will tend to increase the employees' dependence, subordination, submissiveness, which in turn will increase their frustration, and sense of failure, which in turn will increase the informal activities. Management will react to the increase in the informal activities by the formal structure, directive leadership and managerial controls. This closes the circuit and one

⁶ Rogers, Carl R., *Client-Centered Therapy*. Boston, Houghton Mifflin Co., 1951.

has a circular process in seemingly perpetual motion.

THE FOCUS OF THE STUDY AND THE SAMPLE

The objective of the research, conducted in a multi-story manufacturing plant, is to study the mental health of highly skilled as compared to low-skilled employees. Our hypothesis is that since highly skilled employees tend to have a greater opportunity to express more mature behavior (be creative, use many abilities, be challenged in their work, and so on), they will tend to have a healthier work world. This in turn should lead to the highly skilled employees' behaving in more mature ways (as defined by our model above). For example, the high-skill employees (Department A) should express less indifference, apathy, dependence and submissiveness than the low-skill employees (Department B). Also the high-skill employees should express greater sense of self-worth, self-satisfaction, and develop more lasting friendships than the low-skill employees.

Thirty-four employees from Department A and 90 employees from Department B constitute the sample. The schedules of the questions used are semi-structured. They outline specific areas which ought to be covered but leave the interviewer free to decide upon the sequence of the questions.⁷

The interviews were held in the plant, on company time. Notes were taken during the interview and recorded immediately at the end of the day. Interviews were held on different days of the week for a period of seven months.⁸

EVIDENCE THAT THE EXPERIMENTAL CONDITIONS EXIST FOR THE EMPLOYEES

The design of the study calls for *a priori* predictions about employee behavior in

Departments A and B. The differences, if any are found, are to be attributed to the differential characteristics assumed to exist in the technology of Departments A and B. (For example, A gives employees much more opportunity for varied, creative work than does B.) Before the hypotheses can be tested, however, we must show some evidence that the employees perceive the differences between A and B as we assume they do. The researcher's assumption of differences are based upon management's job-classification structure. It is one thing for management to classify the jobs in Department A as skilled and Department B as non-skilled and to pay the employees according to these classifications; it is quite another for the employees to perceive these differences.

Evidence that the employees experience the experimental conditions as the researchers assume can be obtained from a number of sources. Ninety-four percent of the employees in Department A (high-skilled) report that they have jobs in which they experience "plenty of variety," "as much variety as they can handle or more." Eighty-seven percent of the employees in Department B report that they have jobs which are "completely routine," "dull," "monotonous," "with little if any variety."

Further evidence is obtained by analyzing the data related to "perceived personal satisfaction" about their jobs. Eighty-five percent of Department B (low skill) report that they obtain "no satisfactions from their

⁷ For a more detailed discussion see Argyris, Chris, *Human Problems in a Large Hospital*. New Haven, Labor and Management Center, Yale University, 1956.

⁸ A monograph being written provides detailed discussion of the research methods and an analysis of the organization as a social system. This work is tentatively entitled *Theory and Method of Diagnosing Organizational Behavior*.

work excepting good wages." Eighty-three percent of the employees in Department A report that they gain "much personal satisfaction because they have challenging and creative work."

A few qualitative examples to illustrate the differential feelings are:

Department A: "I think the satisfaction I get is to know that I have done a job well. I like to do a perfect job; I like to feel something's done really good; it's really perfect. When I take a look at a piece that I can tell has been made well, I get a real sense of satisfaction."

Department B: 1. "If the work is all right, then I make money, and that's my biggest satisfaction. If I don't, I get pissed off. What else is there to be satisfied about? I learned long ago the only thing you can get out of a good job is good pay."

2. "The only reason I work is to make money. No other reason. Some guys (damn few) say they work for pleasure. They must be bats. How the hell am I supposed to get satisfaction from this job? I'd just as soon get out and dig holes, at least I'd be in the fresh air."

A second assumption made by the research design is that the degree of dependence and subordination required of the employees by the leadership and the managerial controls will not vary significantly between Departments A and B. These assumptions must also be verified as representing reality from the employees' point of view.

Seventy-five percent of the employees in B and 84% in A view the leadership as "excellent because they hardly ever bother us, because they continually try to help us earn good wages and have secure jobs." In discussing the contacts that they have with

management, 63% in B and 68% in A view the management as being "friendly," "down-to-earth," "interested in the employees," and "continually striving to make the employees feel they are not simple machines."

Turning to controls, we find that almost no employees in either department describe the budgets as pressuring them. One explanation of this may be that the budget system is only a few months old and has not had an opportunity to be felt by the employees. Turning to the incentive system, 67% in Department B and 62% in Department A view the piece rates as "being fair," "some rates tough, some easy, but the overall average is fair," and "wish they were slightly higher, but this is not a complaint."

In response to a question on the freedom the employees feel, reflecting on the leadership and the controls together, 83% in Department B and 100% in Department A report they have "as much, or almost as much, freedom as they desire." Finally, in an over-all indication of the degree of pressure the employees feel, 91% in Department B and 100% in Department A say that they "never, or hardly ever, experience pressure."

It seems reasonable to assume that the degree of dependence and subordination required of the employees in Departments A and B does not vary significantly between the departments. This says nothing about the amount of dependence and submissiveness *perceived* by the employees. We are simply saying that whatever the amount is, it is about equal in both departments.

SOME DIFFERENCES BETWEEN HIGH SKILL AND LOW SKILL EMPLOYEES

A method has been developed to infer the predispositions that individuals manifest while at work, plus their potency (in the Lewinian sense of the term).⁹

⁹ Lewin, Kurt, *op. cit.*

TABLE 1

HIGH SKILL	STATISTICAL SIGNIFICANCE ¹¹	LOW SKILL
1. Express a high sense of self-worth and self-regard related to their technological capabilities.	.001	1. Express a very low sense of self-worth and self-regard.
2. Express need to be active.	.001	2. Express need to be passive.
3. Express need to work with others.	.001	3. Express need to be alone.
4. Express need for variety and challenge in their work world.	.001	4. Express need for routine, nonchallenging work.
5. Express need to have some close friendships while at work.	.01	5. Express desire not to make close friendships while at work.
6. Express need to produce quality work.	.001	6. Express need to produce adequate (quantitative) work to make a fair day's pay.
7. Express almost no need to overemphasize the importance of material rewards.	.01	7. Overemphasize the importance of material rewards.
8. Express need to learn more about other kinds of work within the same job family.	.001	8. Express almost no need to learn other kinds of work.
9. Participate in activities outside their workplace judged by the researcher to be creative.	.01	9. Participate in activities outside their workplace judged by the researcher to be non-creative.

A word about our use of the concept "predisposition." For the sake of consistency and simplicity the personality aspects upon which we focus are all categorized as "predisposition." A predisposition is defined as a tendency to act in a particular situation. The predispositions are inferred from the interview data. The analyst combs the interview for any themes from which he can infer the desires that the participant wishes to satisfy while at work.¹⁰ An analysis of these data show that statistically the high-skill (HS) employees differ significantly from the low-skill (LS) employees as follows.

These data confirm the hypothesis that the technology has an impact upon the predispositions and activities of human beings. Further analysis, however, raises the question of how significant this impact is if one is focusing on mental health problems.

THE DEGREE OF SELF-ACTUALIZATION OF HS AND LS EMPLOYEES

The answer to this question becomes evident when we note that the self-actualization scores of the LS and HS employees do *not* differ significantly. Both sets of employees have equally high scores. These scores purport to quantify (in a primitive manner) the

¹⁰ A predisposition is not assumed to be as basic as the "needs" or "need system" postulated by many psychologists. The psychologist's concept of "need" usually refers to those predispositions (to use our terms for the moment) that are more genotypic (that is, they are manifested in many different types of situations). Our predispositions are limited to the organizational context being studied.

¹¹ The probability of obtaining by chance a difference as large as that reported is computed by employing statistical procedures appropriate for use with independent proportions. See Quinn McNemar, *Psychological Statistics*. New York, John Wiley & Sons, 1955, p. 60.

degree to which an individual actualizes himself while in the organization.

TABLE 2

Frequency distribution of self-actualization scores in high skilled and low skilled employees

	HS(%)	LS(%)
0-49.5
50-54.5	2.9	1.1
55-59.5	2.9	1.1
60-64.5	..	3.3
65-69.5	5.9	8.9
70-74.5	5.9	16.7
75-79.5	8.8	11.1
80-84.5	23.6	16.7
85-89.5	20.6	21.1
90-94.5	14.7	10.0
95-100	8.8	10.0

In other words, even though the LS and HS employees differ significantly in terms of the characteristics listed above, their degree of self-actualization is the same. *Thus, in this case, the often-quoted generalization by mental health practitioners that low skill employees will tend to have a lower degree of self-actualization than high skill employees is not upheld.*

SIMILARITIES BETWEEN HS AND LS EMPLOYEES

If the HS and LS employees do not differ significantly in self-actualization, then it must be that in addition to the dissimilar predispositions, they must have similar ones which are of higher potency and which are being expressed. The data confirm this

hypothesis. The four predispositions with the highest potency are similar for both groups of employees. They are:

	FREQUENCY OF CHOICE (Percent)	
	HS	LS
1. To be left alone by management	97.0	89.0
2. To be non-involved, indifferent and apathetic about the formal goals and problems of the organization	96.0	86.0
3. To experience skin-surface interpersonal relationships	96.0	90.0
4. To earn fair wages and to have secure jobs	92.0	89.0

From the first two predispositions we may infer the employees desire to be left alone by the formal authorities and not to be required to become ego-involved in the objectives of the company. Apparently the employees have withdrawn psychologically from the organization. They may be said to be in a state of apathy.

Apathy also seems to characterize the employees' predispositions with regard to their interpersonal relationships with others. We note that they desire few interactions and those to be mere skin-surface relationships. This apathy toward human relationships (as differentiated from apathy toward non-human relationships) may be defined as *alienation*. Employees who are alienated are therefore defined as those who do not tend to desire the rich interpersonal activity usually assumed by some personality theorists to be a basic characteristic of man.¹² In short, alienated people are willing to separate themselves from human relationships.

From the employees' point of view (especially those on low-skill jobs) alienation may be a sensible way to adapt to their working

¹² See Lewin, Kurt, *A Dynamic Theory of Personality*, New York, McGraw-Hill Book Co., 1935; Fromm, Erich, *The Sane Society*, New York, Rinehart & Co., 1955; Sullivan, Harry Stack, *Conceptions of Modern Psychiatry*, William Alanson White Psychiatric Foundation, 1947; Rogers, Carl R., *op. cit.*

world. Why, they reason, should they become ego-involved in a world that will not permit them to express mature aspirations and to gain satisfaction of their adult needs?

At this point, the data simply permit us to hypothesize that the primitive state of interpersonal relationship inferred to exist inside the plant also seems to exist in the activities the employees engage in during their non-working hours.¹³ Thus the employee may be hurting his "long-range self" without realizing it.

Here is an important area for research. What precisely are the mental health implications of prolonged experiences of apathy and alienation? Can prolonged apathy and alienation lead to mental illness? If so, by what processes and toward what types of illnesses?

Returning to the data, one may further hypothesize that the alienation (apathy towards others and towards one's self) will tend to lead the employees in *both* groups to express a low degree of competence in their relationships with people. At the same time, recalling the job differences between the LS and HS employees, we may hypothesize further that only the latter will tend to express a high degree of competence in their dealing with "things." These hypotheses are confirmed. LS and HS employees' sense of competence and regard for their competence in interpersonal relationships is low and about the same for both groups. On the other hand, we have seen (Table 2) that only the HS employees report a high degree of competence in their dealing with "things."

SOME COMMENTS ON THE "HUMAN CLIMATE" OF THE ORGANIZATION

Let us now look briefly at the environmental culture of the organization in which these results are being obtained.

An analysis of the data shows that management believes, *and the employees agree*, that the organization is *not* pressure-oriented. (In fact, in the writer's experience, this is the least pressure-oriented plant he has ever studied.) The leadership consciously refrains from pressure tactics. As to managerial controls, they are just being established. One of the highest officials remarks that if controls upset people, the controls will go!

The employees in both groups report they appreciate the lack of pressure. They are very loyal to the organization, produce an amount that is appreciated by all levels of management, have continually voted down a union, and have a long record of low absenteeism, low turnover, and low grievance rates.

OVERSIMPLIFIED THEORIES OF INDIVIDUAL-ORGANIZATIONAL HEALTH

From the above, it is not difficult to see why both management and employees are quite content with each other and with the organization. Each group feels it is getting what it desires.

On the other hand, the employees report that they desire a world in which 1) they are not required to become ego-involved and made (partially) responsible for the organization's health, 2) they are permitted to be alienated and 3) they are paid well (from their point of view) and guaranteed a secure job. It must be stressed again that no adequate evidence exists to help the mental health practitioner decide how mentally unhealthy or healthy is this state of affairs. (As far as the writer is aware, not even a reliable and valid concept of mental health exists.) It may be that the situation herein

¹³ Argyris, Chris, *Personality and Organization*. New York, Harper & Brothers, 1957.

described is not unhealthy for individuals and will not lead to mental health problems. On the other hand, there is enough evidence to hold with equal vigor the hypothesis that, as Fromm implies, alienation can lead us to become a sick society (8). I tend to believe Fromm has made an important point. However, much research is needed really to test the hypothesis.

The other side of the argument that must be kept in mind is that mental health of the individual is a product of his total life situation. It may be that an individual can endure a significant amount of deficiency in actualization within the plant and make up for it in activities outside the plant. What little evidence I have seen seems to suggest that there is a correlation between the in-plant actualization and outside activities. People with low actualization within the plant do not seem to make up for it as judged by the kind of community activities in which they participate.¹⁴ Recent, and as yet unpublished, research by the writer reinforces the above conclusion. For example, most of the employees (low- and high-skill) do not participate in "outside" organizations in the community. However, systematic research is lacking and no definite conclusions may be drawn at this time.

On the other hand, we find that the managers' concept of organizational health is equally obscure if not invalid. Management is using a set of criteria about organizational health which leads the executives to diagnose the health of the organization as high. For example, they see that absenteeism, turnover, grievance rates are low and that the production and loyalty are high, and on the basis of their theory, judge that all is well. The problem is that their theory about organizational health is oversimplified and internally inconsistent. It

is oversimplified because it does not include the health of the individuals working for the organization. It is inconsistent because it has two inconsistent and independent sets of criteria for organizational health rather than one unified set. For example, management assumes that an organization with low absenteeism, low turnover, low grievance, will also tend to have employees who are productive and who desire to be identified with the company, to participate in all decisions that directly influence them, to worry about making the company more effective, to feel some responsibility for the over-all health of the company, and to develop close relationships with management and each other so that such phrases as "one happy family," and "we're a close company," mirror reality.

Our data show that the above theory is not as integrated as management assumes. For example, the plant has a very low rate of absenteeism, turnover, and grievances. The employees are productive. Up to this point, management's theory holds. The same employees, however, also express little identification with the company, little desire to feel some responsibility for its over-all health, little desire to win promotions as foremen, little desire to have close friendships with management or with each other. Nor do they express strong needs to belong to cohesive groups.

This does not mean, however, that the plant isn't "one happy family." The employees, according to our measures, are very loyal to the organization because they need to be in situations where they are simply asked to produce and not required to become identified with, or deeply involved in, the company. As one employee puts it, "I love this company; it's a wonderful place. They pay excellent wages, give good benefits and they leave you alone. There's a relaxed friendly feeling here. You don't feel the

¹⁴ Argyris, Chris, *ibid.*

constant pressure as you do in Company Y. No sir, I wouldn't leave this company even if someone wanted to pay me more." Thus, strong loyalty is not necessarily built upon an active, interested, healthy employee group. On the contrary, the opportunity to be apathetic, disinterested, non-involved, could generate strong loyalties within the employees as long as wages and job security remain high.

The most crucial needs HS and LS employees report are wages, job security, job control, non-involvement and togetherness, following that order. Does this mean that money is most important? Are we back to the economists' theory of rational man? The answer to the first question is, "Yes," and to the second, "No." If money is important, it is not because man is the inherently rational being pictured by some economists. The employee is still a complex organism with inner strivings to grow, to develop, to have a sense of inner worth. It is precisely because he is not permitted truly to actualize his potential that he makes a decision to "simplify" his personality, making money and other material factors most important. It is as if the employee says to himself, "I want to be a healthy creative human being; I cannot be, and still produce what I am required to produce. Therefore, I will say, 'To hell with my total personality,' and place the major emphasis on money."¹⁵

Such a decision is not a rational one. It is a *deep, emotional, human one*. Nevertheless, it makes money and job security very important to the employee. If this is valid, then administrators of complex organizations are faced with one of the most difficult human problems ever to challenge them. On the one hand, it becomes easy for both the administrator and the employees to de-emphasize human values and to operate on

a *quid pro quo* basis of money, job security, and benefits. As long as a minimum standard of human relationships is maintained, the "rational man relationship" could well flourish. But, as the data point out, such a theory will produce and reward apathy, indifference, alienation, and non-involvement.

RELATING INDIVIDUAL HEALTH TO ORGANIZATIONAL EFFECTIVENESS

If the above is valid, clearly individual and organizational "health" are so interrelated that it may be impossible to consider one without considering the other. Men like Lewin and Harry Stack Sullivan showed years ago that man cannot be separated from his environment. In studying the problems of industrial mental health, it may be that man may not be separated from the organization. The unit becomes the individual-organization.

In stating this position, are we making a value judgment that it is good for organizations to exist? The answer must be provided on two levels. First, as far as the researcher is concerned, organizational survival is not a matter of value. Organizations must exist for the researcher as do leaves for the botanist, human bodies for the biologist, and birds for the ornithologist. Without organizations, the researcher on organizations would have nothing to study.

Turning to the value problem from the mental health practitioner's point of view, the following may be said. Most students

¹⁵ Two points worth noting are: It is not only industry which forces the employee to simplify his personality. The family, schools, churches, etc., may all have similar impacts. Second, the employee is willing to simplify his personality up to a point. This does not mean he will accept money to be treated in an inhuman manner.

agree that, basically, organizations are created by man to fulfill needs that require the collective efforts of human beings. These needs are essential if man is to survive. Thus, stating that organizations must survive is simply affirming the most basic needs of mankind. *It is precisely because human survival and health are crucial that organization effectiveness is emphasized.* Without organizational effectiveness, man could lose his individual health.

This position is openly acknowledged by the employees. Interviews with the employees show quite clearly that they *feel* responsible for keeping the organization alive. The problem, from a mental health point of view, is that they too have internalized management's inadequate standards of organizational effectiveness. Consequently, they too, feel that low absenteeism, turnover, grievance rates and high production imply a healthy organization. They report a high degree of satisfaction with their mental health. In fact, our data lead us to predict that over 90% of the employees and 100% of the management in this plant would resist or even reject a mental health program that attempts to emphasize individual health "vs" or "over" the requirements of the organization. The employees report themselves to be "too realistic" to see such a program as in their interest.

Difficult as the situation may sound, there is at least one possible direction to consider. These feelings of responsibility for organizational effectiveness could become the foundations for the building of an effective *preventive* mental health program in industry. Is it not a sign of some health when

an individual is willing to see himself in a realistic perspective in his relationship with his society? To be willing to give of one's self without feeling one is giving up one's self may be an important building block for a healthy society.

The argument is not being made that an overemphasis on organization could not lead to the ideal of an "organization man" who submits his uniqueness and his health to the demands of the organization. This possibility is admitted and must be avoided. It is the contention of the writer that, in the final analysis, the existence of organization-man is symptomatic of sick organizations. Organizations are tools which help man to survive. They are created by man. Man can change them to facilitate individual growth.

Changing organizations today, however, is a very difficult task and the major barrier is that there exists no theory or empirical knowledge that tells us in which direction changes ought to be made. As mentioned above, the traditional management theories are inadequate, but the new human relations theories may be equally inadequate. One must conclude from this study that the informal employee system, assumed by many social scientists to be one answer to the problem, does not offer a solution. *The informal employee system in this plant sanctions and protects employees apathy, indifference, and alienation.*

Herein lies the challenge of the future for preventive mental health. Much thinking needs to be done on developing dimensions of organizational effectiveness.¹⁶ Much research needs to be conducted on how to maximize individual-organization health. In the organization studied only such a theory would appeal to both the employees and the management, who express a deep desire that the plant must survive, even, if necessary, at their psychological "expense."

¹⁶ For some preliminary dimensions of organizational health, see the author's "Organizational Leadership," ONR Conference, March, 1959, in a book to be edited by Luigi Petruillo.

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CHARLES W. SLACK, PH.D.

Experimenter-subject psychotherapy: a new method of introducing intensive office treatment for unreachable cases

This paper constitutes a report on a pilot study which is presently investigating a new method of introducing "unreachable" cases to psychotherapy. It must be considered a preliminary report. Only 11 cases (all male) have been involved in any way with the new method of treatment and only eight of the 11 should "count." Seven of the eight who "count" are delinquents who are still in treatment with the author and two of his associates as of March 1, 1959, and one was not a delinquent but a conscientious objector whose treatment was successfully completed in about 50 hours. Of the three who "don't count," one was a non-delinquent student whose treatment never really "got underway" in 15 hours and who

stopped coming because school let out. It can't be stated whether or not treatment would have been successful if continued. The remaining two were delinquents whose treatment was interrupted at the very beginning due to circumstances beyond control. One boy committed a robbery on the night after his first two-hour interview, was caught and sent to reform school, and the other went to work after only two interviews and couldn't come at the available hours. Both stated that they would have continued if they could. The author has just started to resume treatment in the case of the boy who was in reform school.

All therapy reported on in this paper was done by the author, although most of the findings have been cross-checked by the experience of at least one other worker. All therapy was recorded on tape. All subjects involved in the project have had at least one thing in common—a high resistance to

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even the idea of going to a psychiatrist or psychologist for any reason whatsoever and especially for help with personal problems. In the case of two delinquents, psychotherapy had at one time been a condition of probation. They never showed up at the clinic where they were supposed to go. Others had had "run-ins" with psychiatrists and psychologists in prison and in reform school and all had a negative attitude toward the professions. All stated that they would never have gone to a psychiatrist or psychologist and all had histories of active refusal to get professional help with personal problems.

A sample of a small number of incomplete cases seen by a single individual is not much to go on in evaluating a therapeutic technique. However, the technique is primarily a technique for introducing treatment in otherwise unreachable cases. Such a method can probably be as well evaluated from cases in treatment as from completed ones. At any rate, the results so far are exceedingly encouraging. Although the number of cases is small, one must remember that they would all be definitely classified as unreachable. This makes the attainment of a therapeutic relationship in even a single case a noteworthy event. Eight or nine cases in a row may very well be a significant trend indicating the effectiveness of the method.

PSYCHOTHERAPY WITH "UNREACHABLE" CASES

Office practice of intensive psychotherapy and psychoanalysis has heretofore been almost impossible with so-called "unreachable" and involuntary cases. Two major reasons for this state of affairs are, first, the high cost of treatment and second, an extensive and intensive resistance to treatment, which includes the act of going to the therapist. Consequently, large and im-

portant groups of patients have gone without study and treatment by the intensive, individual, voluntary methods of psychoanalysis and other depth or "reconstructive" therapies. There is no literature on this type of treatment with such groups as members of religious sects whose beliefs tend to preclude psychology and psychiatry, social deviants who do not wish to be "cured," transients such as gypsies and migratory workers. Others, such as adolescents, are so difficult to work with in office psychotherapy that psychoanalysis, for example, is often contraindicated.¹

Among adolescents there is a group which needs intensive study and treatment in a most vital way. These are the lawbreaking adolescents whose car thefts and gang wars are a major social woe. If it could be demonstrated that some adaptation of traditional intensive treatment was feasible with this group, the demonstration would stimulate interest and serve as a model for the reaching of other unreachable cases.

This paper is intended to describe the use of a new approach to psychotherapy which overcomes resistance and makes possible the conducting of office-type depth psychoanalysis and other forms of intensive psychotherapy with groups such as juvenile delinquents. Although the method does not solve the economic problem, it does not substantially increase the cost of treatment. If individual treatment could prevent crime in any significant way, it would probably pay for itself.

Unfortunately, there would appear to be little hope for the success of individual psychotherapy with delinquents. There is no way in which one can view the record and feel satisfied with the present situation. Healy and Bronner (1) achieved 50% cessa-

¹ Freud, Anna, address delivered at Clark University, 1957.

tion with intensive treatment. However, since this was a "total push" effort involving school, home, and social agencies, and included intensive treatment of parents, the figure cannot represent child-treatment alone. (In another much more recent study involving a control group, those receiving treatment committed slightly more delinquencies than those without treatment.)^{2, 3}

There is no need to go deeply into the failure statistics. Prevailing opinion among informed and experienced workers in the area seems to be that individual treatment is not going to prove a primary means of decreasing delinquency. Other methods which involve *going to* the delinquent and working with him in his natural group (street-corner working⁴) and total residential treatment^{5, 6} seem more hopeful. The trend toward street-corner working and total milieu treatment is not, of course, merely a response to the failure of individual treatment. These methods are valuable and successful in themselves. If individual treatment could be made successful, it could be used in connection with other techniques and might become the method of choice for those individuals who, for one reason or another, fail to readjust as the group acquires new norms. Such isolated individ-

uals do not respond to positive group pressure and the group worker may find he is spending a great deal of time working with a single destructive member in order to prevent him from blocking the group's progress.

It is doubtful whether the poor results to date are representative of the effect which psychological treatment could have if certain very large burdens were lifted from the therapeutic endeavor. Perhaps psychotherapy with delinquents has operated under such handicaps that it cannot properly be called psychotherapy—except in the very rare cases where it "takes" for reasons not applicable to other cases.

In any attempt at treatment the therapist starts at a serious disadvantage. To the delinquent he is an enemy; he represents law and order and is presumed to be trying to convert his patient to the hated cause. Few delinquents come willingly to psychotherapy. The therapist has to convince them that he is friendly and truly permissive.

In view of these difficulties it is not surprising that therapeutic attempts frequently fail.⁷

In part, the trouble lies in misconceptions about the personality and function of the psychiatrist. Instead of viewing him as a person through whom to get help, the working class adolescent sees the psychiatrist as a person to be avoided at all cost. He is afraid of him and that fear is broad and deep.

Like I say, he asked me 'what are you in for?' He was a weird looking bastard—bushy—just like a regular guy you see in the movies—bushy hair—tight, kinky, bushy hair, thick thick glasses and a mustache like a weird looking bastard, man. His eyes look like they went right through you when you'd meet his stare. (From tape-recording of delinquent subject No. 5.)

They give you all kinds of needles in the

² McCord, W., and J. McCord, *Psychopathy and Delinquency*. New York, Grune and Stratton, 1956.

³ Powers, E. and Helen Witmer, *An Experiment in the Prevention of Delinquency: The Cambridge-Somerville Youth Study*. New York, Columbia University Press, 1951.

⁴ Austin, D. M., "Goals for Gang Workers," *Social Work*, 2(1957), 4.

⁵ Redl, F. and D. Wineman, *Control from Within*. Glencoe, Ill., Free Press, 1952.

⁶ Weeks, H. A., *Youthful Offenders at Highfields*. Ann Arbor, University of Michigan Press, 1958.

⁷ White, R. W., *Abnormal Personality* (2nd edition). New York, Ronald Press, 1956, pp. 392-393.

head and fix wires to your brain. I would never go to one of them guys. I don't mind needles or nothin', but—have one of them creeps asking me questions? Later! (From recording of delinquent subject No. 1.)

The fear includes both superstitious and realistic elements. The psychiatrist cannot read minds, but he can lock you up without trial. He cannot turn you into a werewolf (as was done in the film *I Was a Teenage Werewolf*), but he can analyze the things you say and come to the conclusion that there is something wrong with you. Since the psychiatrist is often imagined to be a diabolically powerful person, his inability to render change in a short time may cause severe disappointment and resulting disillusionment.

... I've had times in there, one of the times when I went back I just went in the bunk and I laid down on the rack. I went into the cell and I laid down on the rack and just looked down and ran up and just grabbed ahold of the bars and I just wanted to rip them apart and got all choked up—I didn't cry, one time I almost did cry—I just flipped, though. I flipped my lid one time, I threw the table right at the cell and everything. The screw come up and asked me what was the matter—I told him 'Get out of here,' like that there. So then they sent the guy [prison psychologist] in to see me, some guy who asked me a whole bunch of questions: 'You got any strange habits?' and all this stuff. So I mean, how the hell do they expect you to feel in there? You tell them ... then after a while you say what's the use of telling them guys. ... (From recording of delinquent subject No. 5.)

In some ways it seems as though the entire "doctor-patient" relationship is inadequate.

But it is quite clear that the basic structuring of the physician's role in our society did not come about through the applica-

tion of theories of the ideal situation for psychotherapy. It was a spontaneous, unplanned development of social structure which psychiatry has been able to utilize and develop, but which originated independently of its influence.⁸

The doctor-patient relationship is, after all, a very special transaction⁹ with limits and requirements which involve going and coming, eating and sleeping, tone of voice in talking and obeying of certain commands—just to name a few. It takes years of conditioning, cultural processing and even interested study in popular literature before the middle class child understands what doctors can and cannot do. We cannot expect the working class delinquent to respond to a treatment which begins only after a fairly realistic understanding of this situation develops. Why should a working class individual be expected to see the point of giving up so many hours of his life for a promise of some sort of vaguely defined help?

Spiegel (2) has mentioned the difference in time orientation between middle class American and working class Italian-American and Irish-American. The working class groups put very little emphasis on future time which includes such functions as scheduling and planning. Psychotherapy, basically a middle class institution, demands a high reliability of attendance from both doctor and patient.

Furthermore, there would appear to be a fundamental indignity involved in submitting one's self to examination in very personal areas. It must be proved to be worth it. The doctor, himself, might be living proof of its worth except for the fact

⁸ Parsons, T., *The Social System*. Glencoe, Ill., Free Press, 1951, p. 462.

⁹ Miller, W., "Two Concepts of Authority," *American Anthropology*, 57(1955), 271-289.

that the juvenile delinquent patient has difficulty in identifying with the doctor. He can never be a doctor, is ignorant of his ways, and is suspicious of his motives. The gulf heightens feelings of inferiority which are further increased by those aspects of the treatment which encourage discussion of childish things. The process feels degrading to the patient. The doctor wants the delinquent first to realize that he needs help and then to come willingly to get it. To the patient, it seems as though someone is trying to make him think he is crazy or at least incapable of getting along on his own. The delinquent is extremely sensitive about his needs for attention, love, and help. He is not likely to sacrifice his hard-won pride by giving in to coming day after day when the very act of coming represents an admission of his emotional deprivation.

The act of coming may also represent hostility toward the parents, and some delinquents are very defensive about their parents, being fearful of losing what little support they have. Coming to treatment may also stand for a submission to the will of authority. If that authority makes no believable offer of tangible support, there is little point in offering one's self up to such a schedule.

Important as these reasons are, they are probably not as potent resistances in the single person as when combined with group pressure from other gang members. The individual delinquent gains much of whatever sense of identity he has from membership in the group with which he "hangs." Therefore, he can never be expected to perform an important series of actions which will run contrary to their standards of conduct.

I couldn't show my face back at the corner. They'd say are you buggy or what? That's why I never went. Naw, naw man, that don't go . . . they can't

make a person go. They think they can but they can't. Not if he doesn't want to. (Subject No. 3.)

All in all, the therapist is in a most difficult spot when he tries to treat the involuntary juvenile delinquent patient. His job is not made much easier by the methods of coercion and persuasion which he has at his disposal to make the delinquent come. If the delinquent patient were to come regularly and voluntarily, many of his misconceptions about the therapist, his methods and motives would be straightened out in the treatment itself. If it were socially acceptable to the family and friends and contained tangible rewards or reinforcements, then treatment might proceed without the crippling handicaps now encountered. Instead, the method of coercing—of threatening the patient with prison or reform school for not coming—may even make matters worse. It can cast a dark shadow of open defiance over an already gloomy picture. Coercion may be of some use in those cases where a strong voluntary basis is covered by a veneer of resistance. For example, the patient can say "I'm only going because I have to" and use this as a rationalization for committing a socially disapproved act. By and large, however, it is bound to be of limited value. You cannot force a person to be free; psychotherapy and coercion are antithetical.

The therapist who is treating a patient under coercion must, of course, go to great pains to separate himself from the forcing agent by protesting that it is not he, but the abstract law, who is responsible for the pressure. The therapist must convince the patient of the truth of a really weak argument. "I do not want to make you come; that is someone else's idea. I want you to come; that is my idea. Someone else thinks that you would change and that I'm going to

make you do it and that is why they make you come. They are wrong, I cannot make you change, I can only help you to do what you want to do. And yet I let them do it," etc. The therapist and patient are never more than making the best of a very bad situation. Even if the therapist succeeds in separating himself and his hour from the resentment which surrounds it, the results are likely to be unsatisfactory. If the patient seems to be responding well during the hour, this does not mean that the benefits are generalized. The hour separated from the agency of its existence seems also to be separated from other things of life. Yet there is no method in common practice other than coercion which will bring the recalcitrant and unreachable patient into the office for the first few times. The patient must come once or twice before he can be persuaded to come again.

Persuasion itself may involve voiced or implied promise of infantile gratification or at least parental-like care. There is a hostile implication and an element of deceit in such "seduction." One promises what one does not intend to deliver. Of course, every patient has, to some extent, the wrong idea of what psychotherapy is until his treatment is completed. However, the therapist should not contribute to the misunderstanding by letting the patient believe that his infantile wishes can be gratified during treatment. When the patient discovers that they are merely going to be exposed, his resentment may preclude his experiencing the benefits of the understanding which results from that exposure.

This raises a most important point about the contribution of psychotherapy to reduction of juvenile crime. No method of treatment is going to be effective in cutting down the incidence of antisocial acts unless it contains a sure way to select the cases for treatment. A very high degree of selective

effectiveness is required. It is obviously impossible to treat only those for whom a particular method happens to work. We need to be able to treat those who are doing or about to do the damage. Highly reliable techniques for spotting and getting into treatment those most "inflammatory" cases is a must, if individual treatment is to be more than an expensive game of skill.

All in all, there is a real need for another way of doing things. If the emotional climate which obtains in the successful treatment of more typical neurotic patients, say, of the middle class, could be approximated, then psychotherapy could have a chance. This does not mean that the external situation should be duplicated or that the same mechanisms should be used. To the contrary, major changes in the mechanics of the process must be made in order to achieve the same emotional atmosphere with the working class individual.

The method outlined and illustrated in this paper introduces some basic alterations in the mechanics of the therapeutic process in order to insure the attainment of an emotional setting suitable for good diagnosis and treatment. The alterations also necessitate the inclusion of research aims as an integral part of the individual psychotherapeutic process. Complete recording of sessions is possible, for example, even with patients who would otherwise be much too suspicious. On-the-couch free association has been tried and is workable (although probably not the method of choice with delinquents) and such special techniques as psychodrama and group therapy may be possible although they have not yet been tried.

The method permits high selectivity of cases to be worked with in very intensive treatment, and is therefore expected to enable individual treatment to contribute toward the reduction of juvenile crime.

THE ROLE TRANSACTION

The therapeutic techniques to be described are founded upon and embedded within a role relationship which differs in a number of respects from the traditional one. Instead of working with a transaction based upon the relationship of the physician to his patient, we work with one based upon the relationship of an experimenter to his subject. Basically, the role pattern is derived from experimental psychology rather than from medical psychiatry. It is believed that the experimenter-subject transaction which belongs to the larger class of employer-employee relationships is better suited to psychotherapy with involuntary and "unreachable" groups than is the doctor-patient relationship which belongs to the larger class of professional relationships.

Of course, there are many different experimenter-subject relationships, just as there are many medical ones. The E-S relationship used in psychotherapy with delinquents is that which permits the greatest interaction and mutual exchange of information between the parties. It is not the restricted and distant or "objective" relationship which is very useful in the later stages of scientific work where a precise experiment is attempted and where uncontrolled factors of experimenter bias are removed. At that period of psychological research the experimenter must absent himself, as an unpredictable influence, as completely from the scene as possible, and no real relationship is formed. In the very early stages of research, however, it

is not uncommon for psychologists of even the strictest behavioristic bias to sit down with the subject and listen very carefully to what he says about his experiences. At this point both the experimenter and the subject are phenomenologists and introspectionists, and although what is communicated is heuristic and cannot often pass for scientific fact, it is of the utmost utility as far as discovery is concerned. Finally, after an experiment has been run, it can do no harm to go over the whole thing with the subject. There may be some benefit in it for him as well as for the experimenter. Subjects usually want to know "How well have I done?" The post-experimental inquiry is a natural time to "feed back" knowledge of results to the subject. Often this information can be of use to him, and lead to an attitude change.¹⁰

In E-S psychotherapy the inquiry and evaluation part of the experimental session is lengthened, elaborated, and expanded into almost unrecognizable proportions. It becomes the main body of the experiment, may last years, and provides the structure of a relationship which can be as completely psychotherapeutic as circumstances such as the skill of the experimenter-therapist will allow.

During the time that the E-S relationship holds, the experimenter pays the subject for his services as information-giver. It is essential that the material provided by the subject be of real value to the experimenter independent of its therapeutic value to the subject. Recording of sessions, frequent diagnostic testing and evaluative procedures—indeed, anything which is instrumental to research or a research orientation—is highly suggested. The subject's cooperation is enlisted in the task of "finding out about himself" and at any time he wishes, the experimenter is perfectly willing to spend as much time as is necessary in going over the sub-

¹⁰ Cantril, H., *The "Why" of Man's Experience*. New York, Macmillan, 1950. See, for example, chapter 5. In general the transactional theory, of which Cantril is a leading exponent, is of great help in understanding the novel role relation. The implications of transactional theory for E-S psychotherapy will be discussed in a forthcoming paper.

ject's research protocols, playing back old tapes, talking about the purposes of research (becoming aware of things about people, especially one's self, of which one was ignorant, unclear, or unconscious).

It is important to note that a loose, rather than strict, scientific attitude toward the research is taken with the subject. The subject need not have obsessive concern for matters of differing research philosophy and methodology any more than the psychoanalytic patient should be burdened with the problems of warring factions within that movement.

The relationship allows for a great deal of 'give and take' as to which party is the primary beneficiary of the process of uncovering information. During the early days it is clearly not the subject-patient. He has not asked for help nor yet received it. Later, during those rare and beautiful moments of deep insight and resulting emotional freedom, it is clearly the subject who primarily benefits. After a transition period, a final treatment stage is reached in which the overwhelming emphasis of experimenter and subject is upon helping the subject to become a happier and freer individual. If the subject can afford it and feels it is worth it, he may stop being paid himself, or pay the experimenter.

What kind of research can go on in E-S psychotherapy? Obviously not all kinds fit into the pattern of activity usually called psychotherapy. Are research and treatment really similar enough to permit the therapist to go about both at the same time?

The answer to the latter question is both yes and no. Yes, with regard to the therapist's actions, and no, with regard to his role. The role of the doctor is quite different from the role of the experimenter; however, the experimenter may talk in the same manner and behave in the same way

as the doctor except for stating or implying a contractive agreement to treat.

With regard to treatment, the experimenter's position is something like this: he *wants* to help the subject and may tell him so from the very beginning. The subject may be told that he will be allowed and even encouraged to make use of any and all information available to him and the experimenter to make his life happier in any way he sees fit. The experimenter is under no formal obligation or role-demand to help the subject who is, of course, under no formal obligation to accept help or to change.

The therapeutic pattern of the interaction restricts the kind of research, of course, and limits it to the clinical case-study. It is obviously research into the attitudes and feelings of a single individual, and such results cannot easily be generalized.

We can take advantage of the fact that every therapeutic method yet devised, from hypnosis to non-directive technique, is also a research tool; there is no restriction imposed by the change from a research-centered to a patient-centered focus or back again. The experimenter and subject can continue to do many of the same things while looking at what they do from different points of view. The fact that not all research tools are treatment methods is no problem in view of the fact that all treatment methods are potential research tools.

In general, experimenter-subject therapy places great responsibility upon the experimenter to show the value of his ways to the subject. Real psychotherapy, wherein treatment is actually helping the subject, is not considered happening unless the experimenter and the subject both feel it is. Otherwise, for example, research may be in progress. Objective criteria may be brought to bear by either the experimenter or the subject, but in the end it is the subject who

decides, on his own criteria, whether he is being helped or not. On the other hand, experimenter-subject therapy places *little or no* responsibility for the subject upon the experimenter in the manner of a physician's responsibility for his patient. The experimenter does not promise to take care of the subject—for example, does not give him advice, nor assume charge of his behavior. Furthermore, *there is no real obligation* upon the part of the experimenter to make the subject better in any way. The experimenter helps in every way he can, but makes no promise of cure and treatment and assumes no responsibility for them. If the subject gets better, he does it by himself, with the experimenter's help. It is necessary that nothing the subject can do will "reflect" upon the experimenter. The experimenter is the helper of the subject and not his keeper. Of course, every employer has responsibilities for his employees, including those involving his safety and well-being. The experimenter has, on the other hand, the added responsibility toward his subject in that there may be hidden dangers in any experimental procedure of which the subject is unaware. All in all, the responsibilities of the experimenter to his subject, like those of the employer to his employee, amount to a guarantee *to leave the individual no worse off at the end of his employment, due to conditions of employment, than he was at the beginning.* If the employer, in this case the experimenter, can help to make the employee-subject happier, healthier and more emotionally stable during the course of the job, this is all to the good.

The question comes up of deception on the part of the doctor-experimenter. Is he just fooling the patient and pretending to be his employer, when actually he intends to give treatment, and is he therefore using the experimenter role as a front for other,

ulterior activities? The answer turns out in practice to be a reasonable one. If the experimenter is unwilling actually to give up his role as a doctor, then the business of paying the patient is just a ruse or a trick to get him to come. If on the other hand the therapist drops all pretensions at being a professional, considers himself in every way to be a scientist-employer, puts aside all claims at cure, tries to experiment instead of to treat, promises to study the subject instead of to change him, takes no responsibility for his actions and makes no guarantee except to do him no harm (and to pay him his wages or other benefits or reinforcements), then there is no deception involved.

In simplest terms, the E-S relationship is nothing more than a means of acquainting a person, first-hand, with what psychotherapy really means. After this he can decide for himself whether he wants to participate in it or not, and the decision can be made without the force of the prejudice which preceded that acquaintance. The subject comes to have a more realistic view of the process of treatment and along with it an ever increasing opportunity to help himself through that process. At all times the process is completely voluntary for the subject, who can quit his job at any time he wishes.

There are, no doubt, a number of workers, especially psychologists, who have come in contact with persons needing psychotherapy when those persons volunteered as subjects in psychological experiments. Subject motivation is not well enough understood at the moment to be able to say what part the unconscious desire to get help plays in the act of volunteering for experiments. The experience of professionals who may be doing both research and counseling in a university setting would lend support to the idea that there are a number of people who

would volunteer for an experiment instead of going to the counseling bureau but *for essentially the same reason*. These people are looking for the answer to the question "Is there anything in it for me?" but for various reasons do not take the direct route.

Dr. Richard Alpert, now of Harvard University, reports that, while at Stanford University, he did psychotherapy with a number of former experimental subjects. In one study he interviewed some subjects afterward to find out why their behavior displayed a rejection of the experimenter's instructions. After eight to ten interviews he concluded that these particular subjects were characterized by special problems in dealing with authority in general. When he informed these "deviant" subjects that he had what he wanted for research purposes, over half of them expressed the desire to continue the relationship without being paid. Some even offered to pay for further discussion of their personal problems. In two cases, quite effective long-term treatment ensued.

It is important to note that these subjects were individuals whose subgroup cultural values would not have permitted initiation of therapeutic contact through the usual channels.

The present author tried the same method with a middle-class individual who was a strong-stand conscientious objector. For the last 16 sessions this subject paid the therapist a dollar an hour rather than the other way around. The treatment was accompanied by considerable attitude change including modification of the strong anti-violence position; the subject decided not to go to federal prison for his beliefs.

E-S PSYCHOTHERAPY WITH JUVENILE DELINQUENTS

E-S psychotherapy has been tried, so far, with a small number of delinquent subjects.

The discussion which follows will be restricted to problems concerned with initiating therapy only. The question is one of getting and keeping the subject in the experimental-treatment setting. All other issues including those concerned with conducting and terminating treatment will have to go undiscussed for the present, as will the major question of whether any form of psychotherapy can cut down on crime. Proper experiments have yet to be done which would include control groups who get work and pay but no treatment.

Furthermore, the method outlined should be considered as a working model and not as a finished design. It is probably quite clumsy in many respects. It is not presented in order that it be followed to the letter but in order that it may be *departed from* and altered to adapt to local conditions.

SELECTING SUBJECTS

The subjects involved in the present study were selected on the basis of two criteria. First, that they were true "hard-core" delinquents with long records going back to early years and, second, that they were truly recalcitrant individuals noted for being "impossible to work with" and with histories of active refusal to go to treatment.

Subjects for E-S psychotherapy may be selected on the basis of *any* criterion, however. It might, for example, be advisable to select on the basis of gang leadership, or troublesomeness to a group worker, or delinquency potential in younger children.

THE INITIAL CONTACT

Since E-S psychotherapy is a job and not a treatment, subjects are hired and not referred. The experimenter selects his own subjects on the basis of his own criteria and does not get referrals from other agencies

such as the courts, settlement houses and schools. The experimenter may need cooperation from such agencies to supply him with *information* about his subjects in order that he can have independent evidence of their meeting his qualifications, but he does not need association with existing agencies. He may or may not be a part of a "team" approach, as he sees fit. He is in a favorable position to cooperate with other agencies but he does not *need* to do so. In doing psychotherapy with delinquents it is a definite advantage not to be associated with the police.

The initial contact is made through some responsible person who knows the subject¹¹ and who can arrange to be at a telephone at a time when the subject is also near by. The "contact" calls the experimenter and the experimenter asks to speak to the subject. The experimenter makes a proposition to the subject such as this one:

Miss B. [name of "contact," say a social worker] says that you might like to work for us a while. Maybe you have heard that some of the teenagers are getting jobs where they work for one or two hours a day at two dollars an hour (one dollar for younger kids). Would you like to hear more about it? Well, it's really a pretty easy job and most of the kids like it a lot. You can ask Billy S. (if possible, mention the name of a respected gang member) about it if you want to. You take tests and tell us about yourself. We are interested in finding out about the kids in the neighborhood. I can't explain too much about it—you have to see for yourself. It's not too hard, really, and you don't have to do anything you don't want to. You can quit any time if you want to, and if you

don't like any of the work just tell us and we'll try to fix it up. The pay is good for the hours and you get paid every day, so that you can have a couple of extra dollars this way every day. There's no withholding tax taken out, and you get paid every day. If you want to have another job at the same time we can try to fix it so the hours are OK and you can have both. There is no obligation or anything, just come over tomorrow at 12:30 and you can see what it's like. (Edited quote from experimenter's phone conversation.)

The subject is then given directions for a friend.

You may come with someone you hang with if you want to and we can sign him up on our list, but he can't work now because we are all filled up.

The subject may inquire about bringing finding the lab.

The subject cannot be expected to arrive on time the first time. Several contacts may be necessary before he even comes at all. It may even be necessary for the contacting person to come with the subject on the first visit. As soon as the subject knows exactly how to get to the lab and knows what to expect when he arrives, his attendance should settle down to a predictable, although not immediately regular, schedule.

It is helpful to think of the act of attending as a whole which can be broken down into parts. First we want to get the subject *to come to the laboratory at any time and for any reason*. As soon as the response of coming has occurred it should be rewarded or reinforced with payment. Immediate reinforcement is very important.¹² Next we wish to get the response of coming to occur within an hour or so of the correct time. The experimenter is not fussy if the subject be late or early. Only after the subject becomes dependent upon the money or other support is there an attempt to get him to come at exactly the

¹¹ The author is very grateful to Miss Elsa Baldwin, director of the Cambridge Neighborhood House, for her assistance in acting as "contact" for our subject-patients.

¹² Skinner, B. F., *Science and Human Behavior*. New York, Macmillan Co., 1953.

right time. Lastly, we wish to get him to come for the right reasons—that is not just for the money but for the feeling of relief which is a consequence of the insight and help with problems.

THE FIRST HOURS ON THE JOB

It is very important that the subject be accepted warmly in every way on his visits. The subject is likely to be very sensitive to rejection. Secretaries and personnel other than the experimenter must cooperate to make him feel at home and wanted.

In the first hour, the experimenter elaborates further on the purpose of the research and requests the subject to give it a try. In explaining the purpose of the research the experimenter lets the subject know that he intends to offer help during the process. The subject can be told that most other subjects get more out of coming than just the money and that any time he would like help with a problem not to hesitate to bring it up.

In the initial sessions and throughout the treatment the subject is provided with comforts which one might usually associate with the home. Food such as fruit, tea and coffee, as well as cigarettes and candy, are available and the subject is urged to partake. At times the subject may be given bonuses to get himself special articles of clothing, etc., or as in one case to help him send a package to his brother in reform school. The attempt is to create a nurturant atmosphere, although the experimenter must be careful to avoid a showy display of opulence. A single item such as an orange shared with the experimenter can be a very effective ice-breaker.

Hesitant at first, the subject will gradually come to use all the facilities. He may make it a point to take cigarettes upon leaving and will use the laboratory bath-

room. One subject always interrupts his hour in the middle to use our toilet.

In general, whatever is done for the subject should be done with these thoughts in mind—the subject is basically a deprived individual, no matter what his protests to the contrary. However, he is very sensitive about it. Make no show of wealth before him. Do not offer him what you cannot give (seduction) and do not force too much on him all at once, since he may not be able to take it. Never give a gift which could seem like a bribe. Never tie strings to gifts and never make a gift if it will cause pride to suffer. Pride is ego-strength and must be conserved. Eissler (3) has specified the conditions for gift-giving to delinquents. The author has found his procedures excellent for use within the framework of E-S psychotherapy. According to Eissler, the gift should be given when it is least expected. The author has found that the gift need not be money, however; an unexpected football served as turning point in the treatment of one 17-year-old. It was an ideal gift since it did not imply that the experimenter wanted the subject to “grow up and get a job,” and it was wanted but not “needed” by the subject. On the other hand a gift of money to another subject to get his teeth fixed was a mistake since it did not serve to deepen the relationship and resulted in the subject’s being put in the conflicting position of thinking he must present dire need in order to get a “hand-out.” The subject did not use the money to get his teeth fixed since he was, at the time, afraid to go to the dentist. He felt he should lie to the experimenter about the use of the funds. Furthermore, later on the subject needed money for a gambling debt and pretended a physical complaint. He felt that the experimenter was a “live one” (soft touch). As he got to like the experimenter better he could no longer dismiss his faking as hard-

blooded "conning" and thus felt guilty and ashamed at having to "suck around" for money. This was, of course, a transference of a pattern established at home with the mother and was eventually dealt with satisfactorily by interpretation. Interpretation could not be given, however, until the subject had an outside job and felt the resulting self-respect.

The Eisslerian gift and other similar techniques such as giving an allowance,¹³ providing clothes, and so on, all have their place in treatment of delinquents, but they are rather special ways of deepening the interpersonal relationship and great care must be taken in their use. A 50-cent allowance, for example, may be just the thing in one case but much too "childish" in another.

None of these techniques can substitute for or should be confused with the salary paid in the E-S work relationship; they are entirely independent. The subject may be paid a salary *and* given an allowance, for example; these are two very different kinds of money.

E: Look, R—, you are giving all you earn to your mother, right?

S: Not all, I keep some. I got to buy clothes, you know, and [jokingly] I got to have booze money.

E: Well, I want you to have some money to spend on yourself just the way you want to. If you want to get a quart of beer with it that's okay with me, only just don't blow your top and get sent away. This is not pay for working. It's just an allowance from me. Every week I'm going to give you an extra 50 cents, only I want you to spend it on yourself and not give it away to anybody.

S: You don't have to do that.

E: I know I don't. I have to pay you

because that's part of the job. But this is a gift, an allowance from me to you. I know there are 12 kids at home and there isn't enough to go around there. I got some money from the foundation, so it won't break me. The only thing is I want you to spend it on something you really want for yourself [Jokingly] For example buy a car, okay? (*Conversation with subject No. 6.*)

The subject is paid his salary at the end of each session. To start with, he will most likely spend or give the money away during the interim and return impecunious to the next session.

During these first hours the experimenter makes little attempt to direct the conversation to emotionally laden areas. On the other hand, he does try to get at the facts as seen by the subject. He listens to the subject's "story" about how he is put upon by the police, by parents who are "on his back," and so on. The experimenter unconditionally accepts the emotional message of the subject, although he may register disbelief at some of the subject's attempts to "con" him. For example, the subject will often tell the experimenter "whoppers" about his skills at sports, sex, and crime. The experimenter may register mild disbelief or may accept the lies as truth, but should avoid giving the subject the impression that he (the subject) is being accepted on the basis of the lies. The subject should feel he would be accepted in any case.

We must remember that the subject is not a patient in the ordinary sense of the word. The subject has not come for treatment and may feel very strongly that he wants to work out any problems he has on his own without the help of the experimenter. The experimenter should always passively support these trends. There is no need in E-S therapy for the subject to admit that he cannot work out his problems by himself. Later on, if he really feels he is being helped,

¹³ Kaufman, Irving, "Three Basic Sources for Pre-Delinquent Character." *The Nervous Child*, II, 1(1955), 12-15. Kaufman reported privately to the author that he used a 50¢ allowance successfully with pre-delinquents.

he will probably admit that the experimenter and his ways are valuable to him, but he does not have to accept the experimenter as a therapist until he really sees the point of it.

In the meantime, research goes on. The subject is paid to take diagnostic tests of a very intensive and complete sort. Long-term thematic apperception tests, for example, are given; in these tests the subject is asked to tell many stories about a single picture. We are in no hurry. The idea is to get as complete a picture of the subject as can be obtained; at the same time we are allowing the interpersonal relationship to mature and grow warmer.

During this period, the subject's suspicions regarding the experimenter and his motives are allayed. The subject begins to be familiar with the range of the experimenters' tools—to know which ones he likes and dislikes. The experimenter becomes an anticipatable object to the subject and vice versa. The subject gets to know, for example, that the experimenter never has any contact with the police and, on the other hand, the experimenter gets to know after the first few times that if the subject doesn't show up he is probably, say, at the beach and there's no need to worry, he will come in tomorrow as usual. Another more reliable subject may miss only when in jail. Sometimes it happens that the subject will come, in the beginning, for a few hours in a row and then not show up at all. This is because (a) the habit of coming is not firmly established, and (b) the subject thinks that if he misses a few times he has lost the job. At this point the experimenter must go out of his way to let the subject know by letter, phone and telegram that his hour is still open for him.

Generally speaking, it has not been terribly difficult to get the subjects we want to come to work with us. Now that the treat-

ment is socially acceptable on the corner (the teenagers jokingly refer to the author as the "witch-doctor") it is even easier. Actually we could fill up with cases who apply to us (through friends who are coming), but we have been interested in proving that we can get and keep in treatment those whom *we* select and contact on the basis of our criteria.

It has largely been a matter of persistence. The rules seem to be: Do everything you can to let the subject think the door is always open. Never let him feel that there is any such thing as a final act of staying away. If possible, arrange that the subject "have a lift" for a few times. Never give up. The problem of delinquent attendance is a very different problem from middle class attendance. It is sometimes assumed that, since the delinquent won't come to ordinary doctor-patient psychotherapy, he is incapable of forming deep interpersonal relationships. This assumption is unwarranted. If a middle class patient contracts to do and pay for psychotherapy and then fails to appear time after time, it is often a sign of the severity of the problem. If the delinquent subject says he will come every day at a certain time and then does not show up, it is usually merely a sign that he is not "shaped up" into the habit yet. In the middle class neurotic, attendance failure indicates a breakdown of control mechanisms; in the working class delinquent it merely indicates what we know already—he never learned to schedule his time (2).

THE FIRST INSIGHTS

Unlike patients who come in for help in traditional doctor-patient psychotherapy, subjects in E-S psychotherapy are not asking for help with emotional problems. They may have "a degree of tension, arising from incompatible personal desires or from the conflict of social and environmental de-

mands with individual needs,"¹⁴ but they probably don't recognize it as such or view the experimenter as a person through whom that tension might be reduced.

However, there is one type of complaint which the subject is likely to voice immediately. The subject beefs against society, solid citizens, police and government. He gripes that the police will not "get off my back," that he has done "bum raps," and so on. Even if the subject has the ego-strength to see the fundamental nature of his hostility and dependency upon his parents at the moment, these are presented as reality problems, and his main mode of defense is acting out. Anyone who has tried the approach of attempting to get the delinquent to see the error of his thinking will understand that it is almost impossible to plunge in and prove that his troubles are caused by his own attitude. And yet, surprisingly, this is just what the subject seems to expect and even, at times, desires. The subject expects that the experimenter will try to prove him wrong, and is often afraid that such might really happen. This implies that, at some unconscious level, the subject really wants to give in and be taken over by authority—that he wishes to surrender his will to greater power. Since the subject has had little adult attention to promote identification, he suffers from a strong fear of being a "nothing person."

S: You don't like it, you know? You resent that. I mean like, I mean if they had put me away right then and there for the attempted breaking and entering I would've said, well I'd be bitter that I was away, I'd say "them bastards," you know, and—like that, but still in the back of my mind I'd know that I did it and I'd know that I'd have to serve my time and I'd know that they wouldn't keep me in

there forever, you know, that someday I'd hit the street. But being in there for something that you didn't do, or like that insolence charge, just sticking up, sticking up for your own mother and father, a person that calls them names, you know? That's it, then you look around and say "What the——kind of a country is this?" you know? Even the Russians probably get treated better. Start thinking of all kinds of screwy things, if you had a chance to be a Communist or something, if the guy, if they ever let you out, you know, you'd probably be one and try to get even with them and—like that there. Think of weird things. I know I did, boy, I really hated them. Like I say, I was so——mad I was killing ants and naming screws after ants, naming ants after screws and torture the bastards. Something I look at now and I laugh, I say "What the——was wrong with me?" you know? But I mean boy, you do some . . . and listening to the guys cracking up and going crazy and you're saying "I wonder, I wonder if that can happen to me?" you know, "I wonder who's next?" or this and that, you know? Gee, you get this sense, you just get a real sense that you're lost, that no one can help you, you know? You want to just get out and talk to someone or grab your mother and hug her or your father, and say, you know, say "Make them understand," you know, or something. You're just nothing, it's like not being, not being born, not even being alive, you're just there and that's it. Your body's there and your soul ain't or something. (Subject No. 5.)

The terrific fear of losing his identity makes him extremely wary of any situation where his pride, his strength, his stature or definiteness is likely to suffer. The experimenter and his lab are such a situation. On the other hand, the subject can get strength from the experimenter, he can benefit from his association with him. The subject deeply needs support and protection. This need is so great that the subject must always be on guard lest he be "conned" or "sucked in" due to his immense need for attention,

¹⁴ Rogers, C., *Counseling and Psychotherapy*. Boston, Houghton Mifflin Co., 1942, p. 76.

love and support. This makes the delinquent subject an extremely suspicious person. He does not trust the experimenter to start with. After a while, however, the reliability of the experimenter's support begins to take effect. The subject discovers that, perhaps for the first time in his life, another individual has taken a sincere interest in him and proved it in concrete ways. Just the mere fact that the experimenter can be counted on to be on time and to devote time and money to the subject—to really deliver the promised goods—starts to work some change in the attitudes and behavior of the subject. He begins to skip hours less and less frequently and only with more reasonable excuses. The hour starts to become a very important part of the subject's day; he moves other events around in order to show up on time. Furthermore, the subject is very likely to start giving indications of the development of that phenomenon *which is perhaps the single most outstanding feature of E-S psychotherapy—an extremely powerful, almost overwhelming positive "transference" or rapport with almost no negative manifestation.*

S: Do you, do you get many people? You got many people?

E: What do you mean by that? Well, I'd be glad to tell you. I would be. Only I would like to know why you want to know.

S: Why I want to know?

E: Yeah.

S: I just wondered. I mean I just wondered if there are many people that do this. I mean do you have many people in the day?

E: Do I see lots of people during the day?

S: Yeah.

E: Yeah, well at the moment I'm not seeing too many people. Sometimes I see more.

S: I just wondered how many people you know, were taking you know—

E: Why?

S: Hm?

E: Why?

S: I, it just, it just, just dawned on me that I wondered if you did that, if many people did it.

E: If many people do this?

S: Yeah.

E: You wonder whether what you're doing is—

S: Oh no, no.

E: —something a lot of people do?

S: I just wondered if it was, you know, a big experiment—not experiment, but whatever you want to—

E: Yeah, big one—you mean lots of people?

S: Lots of people and lots of you guys, you know, people like you, doctors like you.

E: Oh, that's other doctors.

S: Yeah.

E: Yeah, lots of them do things similar.

S: I mean right now, in this—

E: In this particular one?

S: Yeah.

E: No.

S: Just you?

E: Just me, yeah.

S: You're from down south, huh?

E: No. Why? Do I sound . . . I mean I'm south of here.

S: Yeah.

E: But not—

S: No, I thought maybe, you know when you said the other day you didn't come from around here.

E: I come from—.

S: Oh, — . . . lives in—, I have an aunt in—.

E: You want to know about me.

S: No, I just, I thought maybe you come from the south.

E: You want to know about me, you want to know how many other people do I see—like that, huh?

S: Nosy.

E: No. You know why? I bet why. Cause I helped you. All right? I think. I think I helped you. I wanted to help you. I thought I could.

S: You'd be surprised how much you did.

E: What?

S: You'd be surprised how much you helped me.

E: Yeah? How much?

S: A lot, a damn lot. More than I could help myself.

E: You needed somebody outside yourself.

S: It worked.

E: What?

S: It's working.

E: It is?

S: Yup.

E: Well how does it make you feel if it works?

S: It's like changing my whole way of thinking and living. Things I didn't, you know, care about—like that.

E: Any bad things about it?

S: All for the best, all for the better.

E: What about the idea of giving up your own way—do you have that feeling? Sometimes they have that feeling, you know? They don't want to—

S: It's changing, it's like changing the whole, my whole way of thinking.

E: How, what else could you describe about it?

S: Well, like things I thought were right before, you know, my way of thinking. I never believed in this stuff before.

E: What about now? You do. So there's something in it anyway.

S: I thought it was all horse—

E: Yeah.

S: Surprising. I mean it—like my brother was kidding me about it—he said they give you all sorts of needles, you know. I don't mind needles or anything like that. He talked about it as though they took you apart. [Laugh] I never believed in the stuff before, psychology or anything like that—I thought it was a lot of—. I didn't think anybody could do that stuff. They can though. Used to read about it in books and stuff. A lot of marlarkey. (*Edited quote from subject No. 3.*)

This lack of hostility is probably a natural consequence of the fact that, in reality, the experimenter is in a much more powerful position in E-S therapy than is the doctor in doctor-patient psychotherapy. Subjects are

loathe to bite the hand that feeds them, and become dependent upon the therapist for some financial as well as psychological support. This finding regarding the lack of negative feelings in the E-S interpersonal relationship needs greater validation with other experimenters and subjects, of course. At the moment we do not have enough cases to be absolutely certain of either the finding or its cause. But, considering the extreme resistance and even open defiance shown by delinquents in traditional treatment, even two or three cases in a row with the opposite effect are impressive.

Once the transference has taken hold and attendance is really regular, the experimenter has a way to go before "therapy" can begin. He must give insight which is truly recognizable as such by the subject and which will therefore give the subject a clear idea of how the process of psychotherapy operates. The initial insights can be used as a model for future therapeutic work and the experimenter can use even a "shallow" interpretation as a prototype. When the situation becomes structured as a therapeutic one, the insight (and the attention and support of the experimenter) become reinforcers of the act of attending in and of themselves. The subject reports that he does not come "just for the money."

E: When you talk to me, does it remind you of anything? I mean is it like anything that happened to you? What's it like?

S: In a way it brings back a lot of things that happened, court and stuff, talking to the guy about the case, or the lawyers, — like that there. But only here, I got a better chance to talk cause I'm doing the talking and you're doing the listening, and there, they were doing the talking and I'd have to do the listening. I'd be trying to put what I, how I felt about it, or what I thought about it, if I was getting screwed, I couldn't, you know, they'd be just talking back and forth, but here it's

different. You got someone to listen, you know? I mean that's what it is, really, I mean you just, you want, you got this stuff built up and you want somebody to listen, you know, you want someone's opinion. What it is, in a way, you're feeling sorry for yourself and you want someone to tell you "Well yeah, you did get a raw deal," you know, that's what you want to know. I mean that's what I'd want to know, you know? Like I'm talking, like I explained the whole case about how I got — up in the bottle deal, you know, how I happened to be standing in town, and here's a person—well it's no skin off your ass by me telling you this, you ain't gonna send me away or nothing. So you're gonna listen and you'll have your opinion, what you thought about it, and whether I was in the wrong or whether I shouldn't have been there or should've been there, who was right, or what, you know?

E: Yeah. Well how does it make you feel, after that comes out, then what?

S: Well it makes you feel better because you get this thing off your chest, and you're different from the people in court, I mean there everyone's, everyone's wrong, you got a record—like I say, everyone's wrong, you know? And you just like for, for instance, a change hearing someone say "Well Jeez, you did get a raw deal," you know. In other words, you understand, you know? what the hell I'm trying to tell you, or what I'm talking about. . . . Um, someone that understands. Someone that you talk to and you know what the hell, or get a good idea of what's going on, you know? Like I say, you ain't the one that's gonna put me away or anything. I mean if you could . . . that's what the feeling you get, if you could sit there and talk to the judge personally and . . . I mean like he just, you're another man. You're there, he doesn't know anything about you, the only thing he knows about you is your record. He doesn't try to figure out *why* you done these things or that you were a victim of circumstance or you happened to be there—he doesn't try to figure out them things, he just goes on the evidence that he's got against you and — like that there—in other words you're

nothing. You just stand there and you wait to get sentenced. And you want to, something's inside of you saying "If you'd only understand, let me explain," you know, "let me explain," and you can't. You can't tell him, you get that feeling that you're just penned in, you can't talk to anyone. Or no one wants to listen to you, they figure you're no good, right away you know, and you try to explain, you try to say "Well look, I'm not no criminal, real criminal, I . . ." you know, "give me a break," or something like that there. Or "I didn't, how am I supposed to know what another guy's thinking. If he throws a bottle out the window—I didn't do it," you know, "what've you got me in here for, why am I being tried? You don't—let me talk to you, Judge, let me explain." But they don't ever give you no chance to explain. That's it, you know? And then you get in there and say "— it, no one's gonna listen to my side of the story." Lot of times, boy, I was on the verge of just, "F— it," I says, "they got me . . ." (Edited quote from subject No. 5.)

SUMMARY

A method for introducing psychotherapy to unreachable cases has been presented with special reference to juvenile delinquents. The method has the following advantages over traditional techniques:

1. Selection of cases for treatment is possible.
2. Regular attendance is achieved.
3. Treatment can be done in one's office: the patient comes to the therapist.
4. A strong positive transference occurs with no negative aspects.
5. Recording of all sessions is possible.
6. Special techniques such as the couch, free association, may be used.
7. Cooperation in diagnostic testing is assured.

8. Procedure becomes socially acceptable to gang members.
9. Therapist does not play professional role in treatment, hence therapist need not be "doctor."
10. Subject does not play patient role and hence there is no stigma of mental illness attached.
11. Treatment is intensive and supportive.
12. There is no restriction regarding approach. Orthodox psychoanalysis, for example, is no doubt possible as is non-directive counseling.
13. Coercion and seduction are not used and subject has feeling of freedom.
14. Medical-type responsibility is not implied in the role relationship.
15. Subject need not admit he needs help in order for treatment to begin.

The method uses a special kind of experimenter-subject relationship as a vehicle through which to do psychotherapy. The major change is the payment of the subject-patient by the experimenter-therapist rather than the other way around.

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GEORGE J. WAYNE, M.D., F.A.C.P.

The psychiatric problems of the elderly patient

Aging is part of growth and development, and the senium comes to everyone who ages long enough. Should we, then, consider senescence a normal part of the adaptive continuum of life? In other words, do we die of some intrinsic, natural impelling force? Or do we die of accumulated physical and psychological assaults which cause deteriorations and eventually reduce our adaptive capacities to zero? Where can the line be drawn between normal and pathological senescence? Or, indeed, can such a line be drawn?

Individual cells have been demonstrated to possess a capacity for immortality. However, as the cells within an organism increase in number—and especially as cell groups become dependent upon each other—their vulnerability increases and deterioration is more pronounced. In the human organism, cells live within a milieu that is

complex beyond description. It follows, therefore, that the vulnerability factor is high, and one can't say with certainty whether senescence and death are functions of individual cells or of the body as a whole.

In the complex external environment in which we live today, the structures by which we function are increasingly assaulted, overtaxed, and often damaged. True, we have succeeded in lengthening the life span by controlling and in some cases eliminating certain diseases. But, offsetting these advances, we find that our technological innovations produce new toxic assaults such as smog and new psychological assaults in terms of additional pressures and conflicts.

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And over and above all is this basic frustration: we are unprepared as a society to utilize constructively the people whose lives we have lengthened.

I am opening up these broad questions by way of demonstrating some of the difficulties implicit in the subject with which we are dealing. The problems of aging and the aged—and the techniques of treating these problems—are still virgin territory. A large literature is developing in the field, it is true, but there are still far more questions than there are answers. We are still not able to define clearly what the aging process is, although we can amply describe an aged person.

So far, in the face of the present dearth of research, we can have only magnificent hunches about these interesting, theoretical questions. And so, without belaboring them further, I'd like to explore some of the psychiatric problems of the aged, and try to take a measure of how these problems can be faced.

The magnitude of the subject can be assessed by the fact that at this moment in the United States there are about forty million people over the age of 50. The reader's first flash reaction might be that 50 should not be considered in the elderly group. But, candidly, we ought not to allow our own personal narcissism to obscure the facts.

Who has not experienced that rather startling difficulty in visual accommodation—and it appears so suddenly!—those increasingly discernible changes in physical stamina, and that pervasive sort of thickening into middle-aged respectability that assails most of use between the ages of 40 and 50?

And if you still resist my placement of age 50 among the elderly, let me bypass that point by telling you that according to present census figures, it is estimated that by

1975, we will have about 18 to 20 million people over 65 years of age.

Obviously, it behooves all of us, as individuals and as physicians, to lend our efforts to preparing ourselves and our society for this great bulge in our aged population. It is not a preparation that can be undertaken superficially. Because, fundamentally, it calls for a change in our culture-bred reverence of youth—in our over-evaluation of the young, in the mythology so stridently fostered by our mass media that only the young deserve love and protection and happiness. In the face of these deeply embedded attitudes, is it any wonder that those of advanced age feel excluded from every facet of life's activities, and experience an increasing sense of isolation?

In older cultures, and even in the so-called primitive ones, the aged enjoy distinction. They are honored and appreciated for the wisdom that comes from weathering the increasingly tumultuous vicissitudes of life. Not so in our culture; we depreciate the "old man" and the "old woman."

Erickson has suggested that there are historical roots for our extolling the virtues of youth. He sees it as a carry-over from our frontier psychology, wherein the persistent goal was to move on to greener pastures. Strength and virility were indispensable in the attainment of that goal, and these qualities quickly developed into and have remained part of the cultural ideal. The enormous popularity of the frontier sagas and cowboy stories in movies and television attests to the soundness of this theory. And a concomitant of this frontier psychology, as Erickson sees it, is that the fear of becoming too old to be easily mobile has cast old age into disrepute in the United States.

Certainly the extension of this attitude confronts us constantly. Rarely is the elderly person accepted within work situations

as a genuinely productive member. The best that he can expect is the condescending forbearance, as though he is being tolerated until a more suitable younger replacement can be eased in. Until then, we put up with the old man—with an attitude of sufferance, we give him a break. Nor is the situation more acceptable or more reassuring for the aged person in the familial setting. In short, there is undeniably a reality point of departure for the specific behavior characteristics of the aged—the suspiciousness, the sulks and the temper tantrums. They are protesting and battling—understandably—against being eased out. And these same behavior characteristics—this irascibility of the oldster—in turn becomes a reality point of departure for the rejecting attitudes of youth.

Perhaps nothing sums up the attitude toward the aged which is now prevalent in our country as eloquently as the cold and business-like manner in which they are disposed of by means of old-age insurance, pension plans, mandatory retirement, domiciliary institutions, and various methods of public assistance. Make no mistake about it, there is real value in all of these programs, but the significant fact is that they have been developed more to discharge our own feelings of guilt than to fulfill the emotional needs of the aged as individuals.

This same unpromising attitude finds reflection in both medical and psychiatric practice. The physician often feels very little emotional involvement with the aged patient; sometimes he frankly considers such a patient hopeless therapeutically. Psychotherapists generally prefer young adults as patients, and in some cases regard advanced age as an absolute contraindication for psychotherapy. Many a psychiatrist completely abandons further exploration as soon as he discovers that a patient is over fifty-five chronologically. He glibly

and unscientifically disposes of the common neurotic problems of the aged by attributing them to "organic senile deterioration."

Let's for a few moments reexamine what we know about aging, to see if we can develop a framework within which to consider the psychiatric problems of this group. Advancing age brings with it, at varying rates in different people, a progressive failure of cellular functioning—a homeostatic decompensation, if you will. These homeostatic decompensations and the special psychologic and sociologic distresses of the aged in our culture don't affect everyone equally. There are those who have a hereditary physical sturdiness, and have lived maturely all their lives with a minimum of emotional turbulence stemming from neurotic conflict. They enter the senescent period with strength, living among friends, colleagues and offspring who admire and respect them.

But reassuring though it is to know that this sort of positive emergence into old age can occur, we know, too, that these people, although fortunate, are not typical. The average older person experiences deterioration, and there is considerable evidence that this decline is *less physiologic than psychologic*.

To be sure, the failure of cellular functioning may indeed be irreversible, although I might comment that some very provocative work is now being carried out which suggests that some organic changes have been *inaccurately* labeled irreversible. But, irreversible or not, we do know that progressive failure on the organic level constitutes added stress which is capable of catalyzing functional mental and emotional reactions. These reactions are familiar to all of you—fear, anxiety, depression, hysteria—and they are reactions which are demonstrably reversible.

The emotional turmoil which comes in

the wake of these reactions can, in turn, affect structures deleteriously, so that adaptability decreases and senescence is hastened. In effect, the total syndrome of senescence is a viciously circular somatopsychic-psychosomatic pattern.

We have all seen dramatic evidences of this pattern in our practice. Patients who are prematurely aged from hypertension, diabetes, arthritis, ulcerative colitis and other chronic gastrointestinal problems, asthma and emphysema have, in many cases, had a life-long history of persisting emotional struggles. I do not necessarily wish to imply a one-to-one cause and effect relationship, but I have little doubt that the concomitant existence of the functional emotional problem and the organic picture are clearly related in some significant way.

It is from this point of view of the interrelationship of the functional and organic, then, that I wish to discuss the psychiatric problems of the geriatric patient. For this purpose a classification of the elderly will be helpful. We can consider four categories—those who are:

(1) *Physically and mentally well and robust.* Such individuals will not concern us as problems, but will interest us as sources of information about healthy aging.

(2) *Physically sick but psychologically well.* Such individuals will be dealt with, essentially, by general practitioners, internists and surgeons.

(3) *Physically essentially well, but emotionally ill.* The neuroses and psychoses of these people are basically the same as those of mentally ill people in any age group. In this category we find psychoneurotics whose conflicts have persisted for a lifetime. We also find old schizophrenics and manic-depressives. There are, of course, some significant differences in elderly patients with

these psychiatric illnesses; the differences will be clarified in this discussion.

(4) *Physically sick and infirm and emotionally ill.* It is categories 3 and 4 that will especially interest us—that is, the emotionally ill, both those who are physically well and physically ill.

An appreciable amount of organic damage can be tolerated in the psychologically well-adjusted. But people whose adaptive capacities were wanting even during the period of greatest physical prowess do not tolerate well, emotionally, the inevitable decrements of what we call “normal” senescence. They feel enormously threatened by the progressive loss of homeostatic ability and the recognition of diminished reserve capacity in dealing with stress. This decline is experienced as an augury of helplessness in a world which isolates and abandons the weak and the infirm. To put it another way, the patient suffers not so much a threat to survival as a threat that he *will* survive, but be impotent, dependent, and uncared for. And if the person who is essentially well suffers with such emotional intensity, those with real physical ailments must suffer even more.

No purpose will be served by my simply enumerating all the diagnostic categories of mental and emotional illnesses in the aged, with descriptions of “typical” clinical pictures of all the various subtypes. The textbooks are filled with nomenclature and classification. As I have already indicated, the elderly may have all the neuroses and psychoses seen in any age group. I would like to touch briefly, however, on several additional factors which we encounter in the aging and aged. One is the involutional states in both sexes, though they are more dramatic in women. Here the interpenetration of the physiological and the emotional changes is exceedingly complex;

it is virtually impossible to determine whether the patient is complaining of physical discomfort or narcissistic injury.

A second and equally important condition which characterizes psychiatric illnesses in the elderly is brain deterioration in its various forms. Among the commonest causes for admission of the elderly to mental hospitals and nursing homes are pre-senile and senile deterioration and cerebral arteriosclerosis. It is rather common to believe that if there are organic brain changes, there must be mental and emotional changes of a specific nature. My experience, along with the experience of many others, does not bear this out. The brain, like other organs, has reserve powers, and often compensates for damage. In fact, certain parts of the brain can be trained to take over the function of destroyed areas—a phenomenon we see in aphasic patients.

I am convinced that the clinical picture we see in any diagnostic category depends on the intimate personal dynamics and sociologic situation of the individual patient and that we should not try to match up stereotyped symptoms with specific diagnoses. Each patient, whether he has evidence of cerebral deterioration or not, must be evaluated within the broad framework of his particular character structure. This involves an assessment of his life stresses, his adaptive capacities and vulnerabilities, the nature of his adjustment since childhood, and his present situation in society.

The management and treatment of the special problems and specific disturbing symptoms of the elderly will depend on many factors. For example, the 65-year old patient who seeks help because of a depression and who has had life-long recurrent neurotic depressive reactions is quite different as a patient-entity from another patient, same age, same complaint of depression, who has essential hypertension and clear

evidence of advanced cerebral arteriosclerosis.

As can be seen, it is of paramount importance to look for a complex of symptoms rather than just a single symptom, and the physical and mental examination as well as the diagnosis should be a collaboration between the general practitioner or internist and the psychiatrist.

Let us consider some of the most frequently encountered specific problems. Perhaps the commonest of complaints among the elderly is *depression*. It is seen in all diagnostic categories. In the involutional states which occur during the period of gonadal decline, it is accompanied by crying spells, agitation and irritability, insomnia, varied vaso-vagal disturbances, and vague somatic discomforts.

In the senile states and in cerebral arteriosclerotic conditions, the symptoms vary in kind and in degree, depending upon the degree and location of the brain damage. We usually encounter a complex of neurological signs, as well as depression, mental confusion, disorientation, and memory loss. In the case of the senile states, there are the added symptoms of increasing apathy and behavioral deterioration.

While I am not overlooking the importance of the structural changes and their specific contributions to depression, I again wish to emphasize the importance of the narcissistic injury. These perceptible evidences of organic decline catalyze a host of very disturbing feelings which augment the depressive reaction. One feels finished, superfluous. One's usefulness—sexually, creatively, productively—seems to be at an end. The sense of isolation increases.

This is exaggerated in more advanced age by the altered and depreciated status in the community. The depressive reactions are often triggered by certain overt occurrences. For example, *retirement* is a com-

mon crisis, especially for someone whose work pattern has been the bulwark of his life. I have in mind people who use work not only as a constructive ideal, but as a defense against many inner anxieties. These are the same people who develop week-end and holiday neuroses, but who are fine when they are on the firing line.

We now know that, even for young people, leisure can present a problem. The problem is compounded for the aging person, who finds himself overburdened with time for persistent retrospection, often with remorseful self-evaluation which may exaggerate old feelings of inadequacy. "What do I do now? What can I look forward to?" are the frustrating questions.

Women experience a crisis which parallels retirement for the man, as their children mature and leave home. It is not at all unusual for the marriage of a child to precipitate a depression in a woman whose entire basis of adequacy was her ability to continue to mother.

Broadly speaking, the loss of a loved one, whether by growth into independent maturity or by death, is a common catalyst for depressive reactions. The special problem of widowhood is quite common. Men marry women younger than themselves—often considerably younger. In addition, women have a longer life expectancy than men—73.6 years for women as compared with 67.3 years for men. This combination of factors has created a special sub-culture of widows whose symptoms and ways of life cover the gamut of psychopathology. Many become desperate in their search for companionship and possible marriage, as their avid appeals in the "Personals" columns will attest. Many of them become prey to the ruthless traffic of fake marriage counselors and "social" clubs. And many, in turn, are quite ready to victimize a prospective husband. I have heard stories of

widows who watch the obituary columns each day so that they can detect that rare bird, a new widower, and phone him, posing as an old friend of the deceased and offering words of solace.

Depression in the elderly is often accompanied by suicidal ideas, which are from time to time implemented. The suicide rate shows a steady increase up to the sixth decade. Some of this increase is undoubtedly a reaction to the onset of organic diseases, especially those with a hopeless prognosis, but the spurt in the suicide rate among the aged is largely accounted for by the generalized depressions that occur at that period.

Hypochondriasis is a common problem in the aged. It represents a return to the narcissistic preoccupation of early life; as the world and its gratifications become progressively more limited, self-concern grows. Interestingly enough, the hypochondriacal complaints of senescence are most commonly associated with gastrointestinal functioning, which is also the major focus of interest of the infant. The oral and anal pleasures of the infant become distorted in the elderly into perverse preoccupation with food, digestion, and bowel functioning. The complaints, in addition, run the gamut of every other organ system, and include strange, often bizarre sensations connected with the cardiovascular system, the nervous system, and all the sense organs including the skin.

It is true, of course, that all organs and systems of the body may call attention to themselves by declining functional performance. But, rather than recognizing and accepting these decrements, many aging persons use them as points of departure for hypochondriacal elaboration. Such complaints almost always become a family concern. Physicians who sometimes become inextricably involved with an aged parent can

readily attest to this. Many have discerned the use of somatic complaints as unconscious ways of regaining positions of dominance, as methods of punishing those who seem to have lost interest, or as devices for obtaining attention so that the feelings of isolation and abandonment are diluted.

Closely related to these hypochondriacal complaints are the chronic states of weakness and fatigue and the specific hysterical exaggerations of loss of functioning. It is often very difficult to determine whether these impairments are essentially organic, essentially neurotic, or both. If they are both, to what extent are they organic, and how much is functional? Losses in particular sense modalities are common in the aged, but so often the deaf will hear what they want to hear, and the partially blind will see what they are curious about. Memory defects, so common in the aged, are often discovered upon examination to be far less than the complaint would indicate. And just recently I saw the case of an aged arthritic patient whose profound locomotor difficulties were aggravated by extra muscular tensions induced by emotional conflicts. After the patient had undergone appropriate psychiatric treatment to decrease these conflicts, the muscular tensions abated, and—arthritic or not—I actually saw her dance!

A vast range of sexual problems are regularly presented to the psychiatrist by aging patients. It is interesting that aged neurotics will often speak with a sense of relief about the freedom which progressive physiologic quiescence has brought them from former tyrannical sexual urges. More often, though, the problem patient complains about waning ability to perform sexually, which gives rise to obsessive sexual thoughts and fantasies and profound feelings of inadequacy and depression.

Although these problems begin most commonly in the involutional period, it is

my impression that waning sexual ability is much more functional than we realize. The connection between sex and sin is part of our cultural heritage, and it is difficult even for a mature person to be able to think of his parents having sexual intercourse. A heavy demand is tacitly made that the aged be asexual.

Nonetheless, we sometimes see aged people whose burden of guilt and anxiety over sexuality has been minimal throughout life. These people seem to defy what is considered the average tendency to age sexually, and give the impression of being excessively virile. It is conceivable that such a level of sexual vigor can become commonplace in a more emancipated, less conscience-stricken culture, and I will have to admit that I hold greater hope for therapeutic benefits from such a socio-cultural change than I do from the injections of new wonder hormones and assorted aphrodisiacs.

Sexual profligacy is not uncommon in the "dangerous" mid-40s—an outgrowth, no doubt, of the feeling that sex may be on its way out. What we have in such instances is a greedy compensatory thrust, occurring, for the most part, in people whose sexual adjustment was never very good anyway, and who always struggled in one way or another with potency problems. This rush of sexual adventurousness often leads to guilt which in turn leads to increasing performance difficulty. Frustration and depression ensue—and ultimately, a visit to the psychiatrist.

In the fifth decade, we occasionally see a breakthrough of homosexual patterns which had been up till then surmounted. Waning heterosexual powers allow this eruption, which may give rise to anxiety reactions and occasionally to acting out of the impulses.

In the sixth and seventh decade, an increase in auto-erotic activity often occurs.

Old genital and anal masturbation patterns may recur. In patients with senile brain disease, sexual perversions may occur in the form of sexual play via mutual genital manipulation with little boys or girls, or sexual exhibitionism. Sexual approaches to mature men and women are uncommon, for the level of performance ability does not generally make this attractive. The continued recurrence of sexual manifestations even in the very old speaks for the eternal youthfulness of the instinctual impulses even though the executive ability has all but disappeared.

Occasionally we are confronted with a special family problem when an old grandpop suddenly decides to marry a very young woman, or the reverse. Obviously, the oldster is moved by a need to recapture his lost youth, and the family by the need to prevent the parent from either making a fool of himself or dispersing the family fortune in a disastrous and unscheduled way.

In elderly patients with organic brain disease or with chronic schizophrenia, sexual fantasies and delusions are common. Delusions about rape, delusional jealousy, bizarre sexual feelings and fears are all seen quite often. In this same category of patients we also see disturbed, agitated, excited, combative behavior, or persistently disturbing delusions and hallucinations—problems which usually result in the aged being forcibly brought into our consulting room, or taken by ambulance to a mental hospital. In some cases the organic deterioration uncovers a schizophrenic illness which has presented only suggestive evidence in earlier life and which is clearly manifest for the first time in the senescent period.

Needless to say, implicit in all the problems and symptoms I have touched upon is a

family problem that seems omnipresent these days—one which doctors are regularly confronted with, either professionally or personally. The recurrent complaint is: "What do we do with our aged parents? They cannot live alone, and they cannot live with us."

When the aged live with their children and grandchildren, patterns of active and passive resistance often develop. The old people complain, either aggressively or by quiet, glum sulkiness, about everything from the alleged sexual licentiousness of the adolescents in the household to the way that the food is purposefully prepared to be unpalatable for them. There are accusations, spiteful behavior, temper outbursts, and sitdown strikes. These are all exacerbations of character qualities which were surmounted in former years of greater usefulness. In other words, the lid is removed from the Pandora's box of character traits by the miserable, dependent status imposed by the mere process of growing older.

The basic solution, of course, lies in restoring to these individuals their own sense of usefulness—and this calls for fundamental socio-cultural changes which we cannot realistically expect to attain in short order. The elderly must be absorbed into society on terms which make honest use of whatever capabilities they have. We must revise our practice of forced retirement at a standard age. An entire repertoire of ways and means must be found to give the elderly a chance to continue to work and enjoy themselves and "die with their boots on." We must stop thinking of age 65 as the terminal point. There are most certainly good years beyond that, and they should not be permitted to stagnate and precipitate suffering simply because we are failing to deal with the problem forthrightly.

The changes which will have to be made to implement a new approach are manifold.

To cite an example: housing for the aged should be developed so that relatively well elderly people can live with others of their own age and interests, with the reassuring knowledge that if they cannot manage independently, they will have access to custodial homes which permit them to have optimal care and to maintain personal dignity. The best in architectural know-how and psychological acumen must be utilized to solve the problem of suitable housing and to develop geriatric recreation centers. Until the housing of the elderly is properly solved, we are going to continue to see vast numbers of aged people inappropriately committed to state hospitals; and third class rest homes and sanitariums, devoid of any type of rehabilitation or recreation programs, will flourish.

Happily, there are some isolated evidences that our past indifference to facilities and programs for the aged is being dispelled. More recreational and activities programs are being developed, although at the moment this represents only a token and a promise of what can be done in the future. For those who are in a sound position financially, extremely comfortable and well administered nursing homes are now available. Perhaps the most heartening of the new developments is the attempt to reabsorb the elderly into the nation's work force.

In Haverhill, Massachusetts, a non-profit group known as Sunset Industries has converted an old school building into an apron factory which employs elderly women. An insurance company in Massachusetts plans to staff its claim-examining bureau with personnel over 65. A business man has employed 200 retired draftsmen living in Florida in a plant he has established there. Other business men have gone to Florida to recruit skilled older workers for plants in their own states.

It is to be hoped that there will be a continued growth of projects which create job opportunities for the aged. There is ample evidence that such projects are not necessarily philanthropic; they make constructive and profitable use of the skills and experiences of the elderly.

Some elderly persons are not easily integrated into projects of this kind. It may be possible to continue with the same or similar occupations on a reduced level in institutions and homes for the aged. In some homes for the aged, shoemaking, dressmaking, hairdressing, bookbinding and printing are carried on, in some cases for profit.

Hopeful as these individual instances are, the sort of profound societal changes which are called for involve virtually a long-term crusade. Meanwhile, day after day, we are called upon to treat the psychiatric problems of the elderly. How much can we do for them? What techniques most adequately meet their needs? I'd like to devote the final span of these remarks to an evaluation of our present therapeutic effectiveness in dealing with these problems.

Psychotherapy for the aged is unmistakably of value, and modified forms of psychoanalytic therapy are also applicable to this group. I believe I am correct when I say that every psychotherapist has had patients in their 50s and 60s who made better use of psychotherapy than others in their 20s, 30s and 40s.

Without elaborating on the special techniques and approaches of the psychiatrist, I would generalize to the extent of saying that appropriate psychotherapy with the elderly has been demonstrated to produce favorable changes in thinking and feeling. As a result, there has been improvement in interpersonal relationships, and a greater facility in accepting the infirmities of aging

and the culture-imposed status problems. Psychotherapy also helps keep the patient as productive and as active as his body and his particular life situation will allow.

Producing deep insight, which is one of the goals of psychoanalysis, is, by and large, of lesser value in psychotherapy of the aged. Accordingly, group therapy is often as helpful for the aged as individual therapy—in some cases, in fact, more helpful, since re-socialization of the patient is often the primary goal. The group situation helps ventilate feelings and thus relieves tensions. The group also aids generally in problem-solving. In many homes and institutions, aged people who have been exposed to group therapy at a level suitable to their capacities have shown improved adaptation and a lessening of inner tensions.

Over and above what can be done for elderly patients through psychotherapy, we have had very creditable results with other forms of treatment, such as electroconvulsive therapy and, within realistic limitations, pharmacotherapy.

Electroconvulsive therapy results in prompt remission of psychotic symptoms in a large number of elderly patients. Persons who do not recover completely often are improved after convulsive treatment and are able to make a stable adjustment within modified or favorable environmental situations with continued outpatient therapy given intermittently. Thus, many elderly patients ordinarily sent to already overcrowded state hospitals can be treated privately and cared for at home during their remaining years.

In younger patients, we tend to stress the value of electroconvulsive therapy in terms of making the extremely depressed or agitated patient amenable to psychotherapy. In the elderly patient, we often use it when we recognize that the patient is not a good candidate for psychotherapy; in other

words, we use the electroconvulsive procedure not as a preparation but as a substitution for psychotherapy. These patients may not be restored to complete mental health by electroconvulsive therapy but improve to a point of partial remission.

Contraindications to the use of electroconvulsive therapy in the aged are much the same as would apply to any age group. Age itself and the frailties associated therewith are not in themselves contraindications.

The psychiatrist must bear in mind the inherently hazardous nature of electroconvulsive therapy. Each treatment carries with it the potential risks of some complications. The psychiatrist must weigh carefully the benefits that may accrue from the treatment and decide if relative contraindications outweigh probable benefits. He must keep in mind the possibility that depressed patients may attempt to escape their problems through suicide.

What, then, is the place of therapeutic seizures in the management of emotional illness in the elderly? It seems clear that prompt symptomatic management in the aged is more justifiable than in youth. Electroconvulsive therapy assumes an important role in the treatment of the aged because of its ability to curtail or ameliorate quickly the emotional disturbance, and to permit the elderly to spend their remaining time in comparative comfort.

I realize that my discussion of electrotherapy has been, to some extent, a yes-and-no affair. But that doesn't hold a candle to what I have to say about pharmacotherapy. Here, I'm afraid my conflicts are very nakedly exposed.

There can be no doubt that pharmacotherapy has proved to be of special value in the treatment of the elderly, but in all frankness I cannot concede to it the sweeping claims which its vendors make. It is very

helpful—but as often as not its benefits accrue to the family of the elderly patient rather than to the patient himself. And, in many cases, its use must be very carefully monitored for side-effects.

To get down to specifics: in many cases the tranquilizers make the problems of management in institutions and in the home much easier, but unfortunately its excessive use will deprive the elderly person of any sense of self-realization which may still be possible for him. The tranquilizer maintains the patient at a level where he does not intrude on his environment, but he is capable of little fulfillment beyond merely existing.

On the other hand, properly used, the tranquilizer may decrease excessive anxiety and agitation, and permit a wider latitude of comfortable activity, if appropriate outlets are available.

I have found the use of various phenothiazine derivatives with meprobamate in combination most effective, provided the medications are titrated by close observation to the patient's needs, so that optimal effect can be obtained. A routine prescription of some standard dosage is almost sure to miss the boat.

The tranquilizers are often depressogenic. This is especially true of the reserpine derivatives, and I am no longer using this type unless I am additionally interested in the hypotensive effect. When a depression is catalyzed by the use of a tranquilizing drug, it can be effectively counteracted by use of one of the psychic stimulants. I have found methyl-phenidylacetate* of special value for this purpose. As a matter of fact, quite apart from the depressions which are related to tranquilizers, other depressive states can be treated by the psychic stimulants such as iproniazid.*

In the case of tranquilizer-induced Parkinsonism, the condition can often be con-

trolled by adjusting the drug dosage, or by using anti-Parkinson medications such as procyclidine hydrochloride.*

There are other medications which fall into the class of the analeptics which are sometimes of value. Reports are often quite optimistic, but I must confess to feeling less than satisfied with the results I have observed, although they are certainly worth trying. These are drugs which contain many ingredients, but the essential elements are metrozol and nicotinic acid, presumably aimed at increasing brain blood supply and oxygenation.

Of course, in treating the elderly, great importance should be attached to the matter of nutrition, special diets, proper caloric intake, and special dietary supplements. The use of hormones, too, is of great relevance. However, this is an approach which is general to the field of geriatrics, and not specifically psychiatric, and so I shall not attempt to cover the subject.

As you can see, we are by no means empty-handed of techniques for the psychiatric treatment of the elderly, but I must admit that there is still substantial resistance among many of my colleagues to undertaking such patients. According to a survey made by the Committee on Aging of the American Psychiatric Association, about 40% of psychiatrists treat no patients over 65 years of age. About 60% treat some aged patients or have research interest. Only 1% spend full time in geriatric psychiatry, and none give full time to geriatric research. I believe that these statistics emphasize the place of special importance that the family doctor plays in dealing with the psychiatric problems of the elderly, and the increasing responsibility he must continue to take as the elderly population increases.

By certain simple measures, the general

* Manufactured under a brand name.

practitioner can do very well as a psychotherapist for many of his elderly patients, even if he has had no formal psychiatric training. First, and perhaps most important, is that he be willing to *spend time* with the patient and listen patiently and attentively. Understandably, the approach of the so-called "pure scientist," with no time to "waste" on the personal element, is even less useful for the elderly patient than it is for other age groups.

The physician must make it clear that his door remains open for future visits and talks, rather than give the patient the feeling that there is no future. During these discussions, simple reassurance and suggestion play an important role. Instruction and guidance can be given about special aspects of health during senescence, such as food and drink, exercise, and the handling

of particular infirmities. The patient should be urged to use his mind and body in all ways that are available and possible for him.

This approach will, I believe, take care of the vast majority of mild neurotic problems. It is amazing what can be accomplished with the elderly when they know they have an interested and responsible friend-advisor-counselor with whom they can freely consult and through whom they can ventilate some of their feelings.

What we can do, to sum it up, is not limitless, but we are not helpless in the face of the problem—and there are still vast and challenging fields to be explored, both within the confines of our own profession and in the broad societal sense, as we push toward our common goal of adding *life* to years, rather than just years to life.

JACOB TUCKMAN, Ph.D.
MARTHA LAVELL, M.S.S.

Effect of removal of overcrowding on patient movement

Administrators and professional groups have long been concerned with standards of care for patients in mental hospitals. Two key areas of concern have been the interrelated problems of overcrowding and understaffing, because of their adverse effects on morale, programming, and utilization of physical facilities. The assumption is that better patient care, resulting from the elimination of overcrowding and the establishment of more adequate staff-patient ratios, will facilitate the patient's return to the community. Experience and observation suggest that this assumption is reasonable but it has been difficult to locate empirical evidence that this is so. The present study will furnish some data relevant to the question.

In Philadelphia before 1956, the main local public facility for the observation, diagnosis, and short-term treatment of men-

tally ill persons was the psychiatric division of Philadelphia General Hospital (a municipal hospital), with a rated bed capacity of 268. The demand for service resulted in considerable overcrowding, a situation of great concern to the hospital board. With the establishment of additional inpatient psychiatric facilities in Philadelphia, the psychiatric division, by board decision in January 1956, formulated an admissions policy which would limit the census to a figure within its bed capacity, without a corresponding reduction in personnel, in order to provide a better standard of care.

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TABLE 1

Personal and social characteristics of unduplicated admissions to psychiatric division, Philadelphia General Hospital, in 1954 and 1957

	1954 N = 1771 %	1957 N = 1791 %	SIGNIFICANCE
Sex			
Male	52	51	**
Female	48	49	
Race			
White	65	60	P = <.01
Nonwhite	35	40	
Age			
Under 15	•	•	**
15-24	11	12	
25-44	45	47	
45-64	24	23	
65 and over	18	17	
Not stated	•	•	
Religion			
Protestant	50	50	**
Catholic	38	36	
Jewish	5	6	
Other or none	1	1	
Not stated	6	7	
Marital status			
Single	32	31	P = <.001***
Married	35	31	
Widowed	14	13	
Separated or divorced	15	20	
Not stated	4	4	
Previous admissions			
Yes	18	25	P = <.001
No	82	75	
Mental disorder			
Brain syndrome (acute, chronic)	25	26	**
Mental deficiency	2	1	
Psychotic disorders	44	47	
Personality disorders	6	5	
Character disorders	7	6	
Not stated	•	1	
	7	4	
	9	11	

The purpose of this study is to compare the movement of patients admitted in 1954, when the average daily census was 368 or 137% of its rated bed capacity, with that of patients admitted during 1957, when the average daily census was 250 or 93% of capacity. In the latter period, it would be expected that patients would spend less time in the hospital and/or that a higher percentage would be discharged to their own homes.

A study had previously been made of the characteristics of unduplicated admissions to the psychiatric division of Philadelphia General Hospital for the year 1954.¹ This study was replicated for the year 1957. The calendar year 1957 was selected rather than 1956 because it was felt that the full effects of the new admissions policy would not be reflected until that time.

A comparison of the 1954 and 1957 unduplicated admissions on a number of personal and social characteristics, given in Table 1, showed no significant differences with respect to age, sex, religious affiliation or diagnostic classification. However, the 1957 group showed a higher proportion of nonwhites, reflecting their increased proportion in the Philadelphia general population, and a greater incidence of separation and divorce. The 1957 admissions also showed more chronicity—that is, a history of previous psychiatric admission to Philadelphia General Hospital or to public or private psychiatric hospitals. Since patients with previous psychiatric hospitalization remain in the hospital for a longer time than those without previous admission,² it would appear that the 1957 admissions were biased somewhat in the direction of a longer hospital stay.

With respect to personnel, there were 52 psychiatrists (residents, visiting chiefs, assistant chiefs, and permanent staff) in 1954 and 53 in 1957. The nursing staff (graduate

nurses, practical nurses, aides) numbered 122 in 1954 and 123 in 1957. Collaborative personnel (occupational therapists, psychologists, and social workers) numbered nine in 1954 and 10 in 1957. Figures were not available for student nurses and voluntary recreational aides. However, it was reported that there probably was no difference in the number of student nurses and that there were more voluntary recreational aides in 1957 than in 1954. Although it was not possible to determine accurately the amount of total staff time available in the two years, it seems reasonable to say that there was little difference in overall personnel.

In common with psychiatric practice generally, less emphasis on insulin and electroconvulsive therapy and considerably greater emphasis on the use of tranquilizers were reported for the year 1957 than for 1954. However, there was also greater emphasis on relationship therapy and increased use of occupational and recreational therapy. There was improved morale because of a more equitable work load and a more favorable working environment. There was no difference in the number of state hospital beds available to the psychiatric division for patients requiring such care. In 1954, the staff was under considerable pressure to move patients out of the hospital as quickly as possible to make room for others, while in 1957 the criteria for discharge were more rigid.

RESULTS

There was a somewhat greater number of admissions in 1954 (2,097) than in 1957 (1,963). However, these figures include

1 Tuckman, J. *Characteristics of Patients Admitted to the Psychiatric Division of Philadelphia General Hospital in 1954*. Philadelphia Department of Public Health, Division of Mental Health, 1955.

2 *Ibid.*

TABLE 2

Average length of hospital stay of admissions to psychiatric division, Philadelphia General Hospital, in 1954 and 1957, by race and sex

	AVERAGE LENGTH OF STAY, IN DAYS	
	1954	1957
White males	49.5	41.7
White females	71.0	52.9
Nonwhite males	51.1	39.6
Nonwhite females	69.6	57.5
Total unduplicated admissions	59.9	47.6
Total, admissions and readmissions	64.0	46.4

duplicated admissions, that is, patients who had been admitted more than once during each particular calendar year. When unduplicated admissions only are considered, the number of different persons served was about the same: 1,771 in 1954 and 1,791 in 1957. Moreover, the number of subsequent readmissions during the same calendar year was lower for 1957 than for 1954: 172 and 326, respectively.

If a smaller number of beds serves approximately the same number of patients, the length of hospital stay must necessarily be shorter. This is demonstrated in Table 2. In 1957 the average number of days of hospitalization was considerably less than

in 1954. This applied to both men and women, to white and nonwhite, and to total admissions, duplicated or unduplicated. The total number of days of patient care for duplicated and unduplicated admissions combined was 91,102 in 1957 and 134,124 in 1954.

Not only did patients spend a shorter time in the hospital in 1957 but a larger proportion were discharged to their own homes and a smaller proportion admitted to state hospitals (Table 3). Also, the number of deaths, while only slightly less in proportion, was considerably less in actual numbers, 82 in 1954 and 46 in 1957. This finding, as well as the fact that more patients were transferred from the psychiatric division to other wards within the hospital for appropriate medical-surgical attention, suggests better care of the patient. It is interesting to note that the amount of reduction in hospital stay was as great for those transferred to state hospitals (average days 74.5 in 1954 and 62.4 in 1957) as for those discharged to their own homes (average 50.3 in 1954 and 42.8 in 1957). The reduction was even greater for those discharged to police or correctional institutions (average 55.6 and 39.2, respectively).

DISCUSSION

It is doubtful whether the changes in length of hospital stay and in disposition of patients in 1957 from the 1954 period can be attributed merely to the increased use of tranquilizers. Brill and Patton^{3, 4} have attributed important increases in discharge rates and decreases in the patient population to the widespread use of tranquilizing drugs. However, it is not known how much these changes were due to other factors such as better standards of hospital care, improved staff morale, or enthusiasm about the use of the new drugs; nor were data reported comparing the discharge rates of

³ Brill, H. and R. E. Patton, "Analysis of 1955-1956 Population Fall in New York State Mental Hospitals in First Year of Large-Scale Use of Tranquilizing Drugs," *American Journal of Psychiatry*, December 1957, 114:509.

⁴ Brill, H., and R. E. Patton, "Analysis of Population Reduction in New York State Mental Hospitals During the First Four Years of Large-Scale Therapy with Psychotropic Drugs" (abstract), *Scientific Papers of the 115th Annual Meeting of the American Psychiatric Association in Summary Form*, 1959.

TABLE 3

Disposition of unduplicated admissions to psychiatric division, Philadelphia General Hospital, in 1954 and 1957

DISPOSITION	1954	1957
	N = 1771 %	N = 1791 %
State hospital	38	33
Home	46	52
Police or correctional institution	6	4
Other wards of hospital	3	4
Died	5	3
Other	2	4
Not stated	1	0

$$\chi^2 = 67.047 \quad df = 6 \quad P = < .001.$$

patients who received tranquilizers and of those who did not. More relevant to the present study, which is based on short-term patients, was the finding by Brill and Patton that the effect of the tranquilizers was least among newly admitted patients (hospitalized for less than one year).⁵ In other studies, the effectiveness of the tranquilizers had been questioned. For example, Little⁶ and Rathod⁷ reported that placebos were as effective as tranquilizers in the treatment of psychiatric patients, which suggests that the attitude toward the drug is as important as the drug itself. Whatever the outcome of future research, it is questionable whether any one technique can be considered the determining factor in patient movement. For example, in 1955, a period in which an increased use of the tranquilizers over 1954 was reported but before the change in admissions policy at the psychiatric unit, the average length of hospital stay was 65.2 days, a figure no lower than that in 1954. It seems, therefore, that the effectiveness of any drug or procedure depends upon the

adequacy of the treatment program as a whole. The most reasonable explanation for the changes in length of stay and disposition of patients, found in this study, is better patient care resulting from improved standards of operation.

SUMMARY

Admissions to the psychiatric division of a municipal general hospital were studied before and after changes in admissions policy. The study indicates that service was improved when the unit operated within its rated bed capacity and with a better staff-patient ratio. Under more adequate conditions, not only were as many different patients served as under poor conditions but the number of readmissions within the same calendar year was reduced, the length of hospital stay was shortened materially, the number of deaths was cut down, fewer patients were committed to state hospitals, and more returned to their own homes. Not only did the patients receive better care as measured by the above factors but the community benefited because of reduced costs of operation.

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⁵ Brill, H. and R. E. Patton, "Analysis of 1955-1956 Population Fall in New York State Mental Hospitals in First Year of Large-Scale Use of Tranquilizing Drugs," *op. cit.*

⁶ Little, J. C., "A Double-Blind Controlled Comparison of the Effects of Chlorpromazine, Barbiturate and A Placebo in 142 Chronic Psychotic Patients," *Journal of Mental Science*, April 1958, 104:334.

⁷ Rathod, N. H., "Tranquillisers and Patients' Environment," *Lancet* (Lond.), March 22, 1958, 1:611.

JOSEPH HIRSH

If suicides gave their reason for the act in set terms not much light would be thrown on the matter. But this is precisely what everyone who hears of a suicide tries to do. All he really accomplishes is to reduce the case to his own language, thus making it something different from the reality.—G. C. Lichtenberg: "Reflections," 1799.

Suicide

PART 3: DYNAMICS OF SUICIDE

Statistics are the structural steel on which the story of suicide is built. Demography (1) provides some host and environmental girders. A study of the agents and methods involved in the suiciding process (2) provide other structural elements in the epidemiological triad. But all together, however elaborate, they do not complete the story. For suicide, in the final analysis, is a dynamic process precipitous in its final phase but usually long-term in development. It is a strange process often potentiated by host or environmental factors which appear to be benign and innocuous. But whether the process is short or long, however relevant its potentiation may be, and whatever its

myriad forms may take, the central ingredient of suicide is death. Without the conceptualization of death there apparently can be no suicide.

A review of the literature on animal behavior suggests that though animals may pine away, feel sorrow through loss, act pathologically depressed, even experience a kind of *anorexia nervosa*, they do not actually commit suicide. And the reason for this is that they apparently have neither a consciousness nor a conception of death. Thus, it appears that suicide is a phenomenon copyrighted by man.

In order for the suicidal process to take place successfully there must be the critical convergence of host, agent and environmental factors in the same manner that a critical mass must be produced to create an

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A-bomb explosion. But such convergence just does not take place magically. It takes place because of a variety of host factors influenced by concepts of death in a culture which itself sanctions, conditions or determines suicide.

When people do not fear death it is generally because they have no real comprehension of it; they cannot conceive of its meaning, its shape and form. And mostly they cannot accept its finality. It is perhaps for this, more than for any other reason, that man has created religious and philosophical systems in which if there is no outright denial of death there is the prominent statement of immortality or continuity. The failure to comprehend or accept the finality of death is an important feature in suiciding in the young, the aged and among certain primitive peoples who do not perceive the suicidal act as essentially one of self-destruction.

In ancient times and even among primitive peoples today suicide is understood chiefly in demonologic, magical or theologic terms. Many people believed that as a demonologic or magical phenomenon it is planned, prompted or dictated by external agents or forces which might effect the act from outside the individual or by entering the individual in advance of the fatal act. Suicides tended to identify with these powers, thus attaining magical or charismatic power.

Suicide not only fulfills a variety of functions but seems to be sanctioned in quite a few primitive societies. In some of them suicide is the only way out when an individual has been affronted—that is, has lost face. In others it is the only way out when the individual has inflicted the affront. Suicide everywhere and in every time is a frequent concomitant of unhappy love affairs. There is hardly a country, primitive or sophisticated, which does not have some

rock or promontory, some crater or waterfall dedicated to the suicide of lovers.

In the Far East the concept of saving face is often a central feature in suiciding. Injured insufferably, especially when retaliation for the affront cannot be taken or the injury assuaged, there is still a recourse to the highly hostile act by suiciding at the enemy's very doorstep. In essence may this not be the principle underlying the extreme actions of the *Kamikazi* pilots of World War II notoriety?

Malinowski (3) tells how the Trobriand Islanders deal with an egregious insult. The injured person climbs a high palm tree, harangues his listeners on the evils of his enemy and the wrong he has done, and then dives head-first to his death.

Suicide is culturally conditioned in many ways. The Zunis, according to Ruth Benedict (4), value moderation and sobriety above all other things. The mere mention of suicide would be greeted by incredulity. Benedict describes by contrast the Dobuan people, a group marked by hostility and spitefulness, who customarily express their resentment by attempting suicide. Still another group studied by Benedict, the Kwakiutl, who have strong feelings concerning rivalry and envy, suicide in response to a shameful setback.

Suttee was a practice of culturally sanctioned homicide in India dating back to the fourth century B.C., involving the burning of a Hindu widow on her husband's funeral pyre. It took on the characteristics of culturally sanctioned suicide when the widow to prove that she had been a true and faithful wife requested suttee. Under the Brahmanic code the suttee was promised 35,000,000 years in Svarga and the veneration of her spirit as a saint with great healing powers as her reward.

Two central concepts surround suicide as a theologic phenomenon, that of relating

the dying process to returning to the original source of life—namely, God—and that of viewing the act as a surcease and release from this vale of tears and the beginning of the promised new and eternal life of peace.

Brahman and Buddhist beliefs sanction suicide in their view that the body is a dwelling place to be abandoned at the will of the owner. Mohammedanism, Judaism and its Christian derivatives, on the other hand, condemn suicide.

In many societies, ancient and modern, primitive and sophisticated, the act of self-destruction is often fantasied as multiple destruction. In those societies where suicide was viewed as a crime, it may be that man unconsciously had an awareness of suicide vicariously constituting multiple murder. Thus, in medieval society the suicide was treated legally as a murder, his naked body carried through the streets to be buried at a crossroad with a stake driven through his heart.

However much suicide may be sanctioned, most cultures regard it as irrational. To be sure, some suicides are clearly the acts of frankly disturbed or deranged persons who, at the height of their agitation, extinguish themselves. Their final acts are generally spontaneous and apparently without premeditation. Other suicides, reflecting a quiet desperation, exit in a manner which appears to be consistent with their mood. The logic of their final act seems as incontrovertible as it is irreversible. Both, however, must be regarded as irrational.

✓ But are all people who suicide emotionally unbalanced? What of the individual whose reasons for suicide are rational and logical, who is not desperate in the present but who wishes to avoid a painful, helpless or hopeless future in infirmity and disease? Is suicide for him also to be regarded as irrational? If we look to the apparent or stated reasons we might be in-

clined to say "no." But if we look to the *method* rather than to the apparent motive the answer is often clearly "yes," for rarely does the so-called logic of the motive permeate the method. If the avoidance of pain, for example, is a central feature of the motive should not the method be as quick and painless as possible? Yet it often is not. And this in spite of knowledge, sophistication and the availability of pain-free means of self-destruction. Take physician suicides, for example. Despite professional training, technical know-how and the availability of a variety of sure-fire, pain-free ways of exit, they sometimes are most painfully or naively self-destructive. What this suggests is that however rational the motives for suicide may be the act of suiciding itself is often an irrational one.

But if suiciding is irrational, is not life itself in many instances equally irrational? Take the millions upon millions who eke out their lives in squalor, misery and disease. Take the wartime horror of the concentration camps. Why did people hold on so tenaciously to the flickering spark? Why should survival be so imperative? For the one, the suicide, may it not be that he sees the act of suiciding not necessarily one of self-destruction, but a way of imposing guilt on others, the reconciliation of a lifetime of frustration or the achievement not of death but of immortality? For the other, the individual determined to maintain even the dimmest spark of life, is not survival the symbol of eternal hope? The answers are hard to come by, but modern psychiatry has formulated a number of persuasive notions, the most intriguing of which are the psychoanalytic ones.

✓ Freud formulated a central idea that the state of depression results from the failure to externalize aggressive feelings. These are therefore turned inward and, when they take the form of unconscious sadistic fan-

tasies, may result in acts of suicide. Karl Menninger (5) elaborated this concept in stating that suicide is derived from an aggressiveness which is crystallized as a wish to kill, an aggressiveness which is modified and expresses itself as a wish to be killed, or a modification of primary aggressive urges which crystallizes itself in the wish to die.

The late Gregory Zilboorg, posited (6) sociologically that suicide is a way of thwarting those external forces that make living impossible. He has also restated (7) the magical formulation that in killing oneself one gains immortality and fame, thereby maintaining the ego rather than destroying it. Other psychoanalysts point to suicide as an expression of early influences and patterns, such as aggressiveness, narcissism and arrest in psycho-sexual development.

Suicide may express itself in the wish to punish a depriving or rejecting figure (parent, sibling or, by extension, all parents and siblings—that is, society) by inducing in them a feeling of guilt. "You'll be sorry if I die" is the central thought of this fantasy—as if the suicide expected to be around and see their reactions when his relatives viewed his body or were notified of his death. In this way the suicide manipulates himself into killing himself at the same time that he denies his own death. This is the adult counterpart of the spite motive of child suicides.

Children by and large have no fundamental consciousness of what death is really like despite the fact that they understand its meaning in terms of such artifacts as funerals, coffins, burials and cemeteries. Despite the fact that they do not believe that they will die, and hence do not relate death to themselves in the present, they almost universally declare that they do not want to die. In short, death has no immediacy, no relevancy for the present, and is

a reality only for the remote future and for the aged. In order to be accepted in the child's consciousness in the present, death, whether it be from disease or other causes, seems to be understandable in the context of violence and dismemberment. Outside of this context death among very young children is often regarded as a reversible process and not as something definite and final. Thus it is easy for children to wish the death of others or themselves, or to speak in the most casual terms of killing people without restraint or the apparent feelings of a stricken conscience.

A number of psychoanalysts feel that suicidal attempts in children are a reaction against loss or deprivation of love. In attempting suicide, the child actually does not see himself as killing himself. He views the process in one of three main contexts. First, he may see it being thwarted and believe that in such thwarting he will be given the love he has been denied. A second context, in which death as a configuration itself is quite real, revolves about the wish for reunion with the lost object of affection, such as a dead parent; suicide is visualized primarily in terms of reunion with the loved one. Finally, where death is a real factor to the suiciding child, it is often used, as already indicated, as an element of spite and revenge, of punishing an offending individual.

Mason (8) described three adolescents who attempted suicide, using their physical condition as the means of self-extermination. All were diabetics. In one case the patient refused to eat after having taken insulin, stating "I won't eat so I'll die." In other instances she refused to take insulin. This patient was constantly able to provoke diabetic comas or to produce states of insulin shock. In another case the patient refused to maintain her diet or to take in-

sulin. When a leg ulcer developed she refused to take even the most hygienic measures to care for it.

✓Suiciding in older people has its special characteristics and patterns. The breakdown of relational systems, the loss of position in the family and the community, and the general decline of status and role, characterize the aging process. The feelings of insecurity and inadequacy thus engendered produce in some people set patterns of reaction and even cantankerousness and depression in others. Those in the first group may be viewed as still rebelling at what life has done to them. Those in the second group feel that life has left them behind and that, like the rejected child, they are deserted and desolated. They withdraw within themselves. They become preoccupied with the past. They become more and more isolated, more and more depressed, more and more subject to illness, more and more preoccupied with death.

Thus young and old in suicide seem to have much in common and apparently for the same reasons. In the first place they rarely see their act as a terminal one ending in death, but rather as a process. This is a process of either inflicting guilt or causing pain to the persons or their symbols central to, or responsible for, the "loss" they have sustained. The process may be directed towards eliciting love and affection, or it may be one by which the suicide seeks to be reborn or reunited with his lost, loved ones.

In the young, adult and aged there are as many bizarre methods as there appear to be motives for suicide. But from it all studied together, they reveal three central features which come close to being constants in the suicide constellation. In these days of alphabetic contractions we might call them, the LAD syndrome. *L* stands for loss,

which seems to be the one, single, central etiological feature of suicide. Loss may be real or fantasied. It may involve loved ones, self, image of self or functions. And loneliness is an almost constant concomitant of loss.

A stands for aggression, which Freud, Menninger and others have pointed out constitutes the chief affective force behind suicide. When this force is externalized it may express itself as homicide, which some psychoanalysts and sociologists regard as the obverse of suicide. When it is internalized it often expresses itself as suicide.

Finally we come to *D*, which stands for depression. Except for the highly agitated unpremeditated suicidal act of the psychotic, in which it is difficult to determine precisely what affects are present, depression seems to be a cardinal characteristic of most suicides.

Three simple facts stand out with reference to depression. First, it is often the central feature preceding or predisposing to suicide. Second, "the sixth decade of life is the period in which pathologic depression is most likely to appear or is likely to be most severe if episodes of depression have occurred earlier," according to Dr. Mortimer Ostow, who has made a special study of this problem. Third, normal depression is often self-limiting and self-resolving, while pathologic depression rarely is and more often than not requires heroic treatment. The difference between the two is of fundamental importance.

Depression is a psychic affect related to loss—anticipated, actual or fantasied—through death, departure, separation or rejection. It may involve parents, brothers, sisters, wife, husband or friend; it may involve part of self through amputation; it may involve image of self through disfigurement or aging—that is, loss of status in the

family, job, or sexual prowess. Ostow has posited that "where the degree of depression is commensurate with the magnitude of the loss, we consider the depressive reaction to be a normal response. Where no loss at all is visible or where the degree of depression is disproportionately great, in the light of the actual loss, the depression is considered pathologic" (9).

In many illnesses, both acute and long-term, there is often a definite depressive phase. Once the acute stage has passed, and the wearisome bedridden, wheel chair, hospital or house imprisoned aspect of long-term illness begins to brand itself upon the patient's consciousness, depression can be anticipated and expected. This is especially accentuated where the prognosis is poor. Tuberculosis, cancer, general paresis and pernicious anemia are typical of those conditions in which pre-suicidal depression can be expected. Traumatic injuries and disfigurements similarly may evoke serious depressive reactions.

In his lucid anatomy of depression Ostow points out that aggression is a frequent component of normal, and a constant component of pathologic, depression—the most striking and dangerous aspect of which is self-directed aggression. He states: "The patient scolds himself, starves himself, will not permit himself any enjoyment, rejects any erotic approaches and finally may commit suicide. Such behavior is considered to be aggression directed against the self because it is clear that the patient does to himself what psychoanalytic investigation discloses he wants to do to others."

Ostow, in explaining the development and dynamics of depression with its many counterpunctual moods and plays, points out that "suicide offers itself to the depressed individual as a particularly satisfactory method of resolving his depression."

Sociologists were the original pioneers in

the scientific study of suicide. They were among the first to collect and develop data on suicides. Later they elaborated a number of theories on the etiology and dynamics of the suicidal act. If Freud may be credited with fathering the psychoanalytic theories of suicide, Emile Durkheim is equally the progenitor of the sociological theories.

Durkheim (10) described three basic forms of suicide—anomic, egoistic and altruistic. Anomic suicide was held to result from severe and usually sudden dislocations in the economic environment. Durkheim suggested that "poverty protects against suicide because it is a restraint in itself . . . the enormous rate with those of independent means . . . sufficiently shows that the possessors of most comfort suffer most." These observations have been corroborated by many others.

In the United States suicide is more common among the privileged than among the deprived. According to the distinguished public health statistician Louis Dublin (11), suicide appears to be concentrated among the well-to-do, despite the fact that it occurs at both ends of the socioeconomic scale. He found likewise that suicide rates fluctuate markedly with economic cycles.

Egoistic suicide reflects a failure in the individual's integration into society. The concept relates more closely to host inadequacy or failure, in contradistinction to anomic suicide which focuses on the external environment. As such it approaches fundamentally the psychoanalytic theories.

Finally, there is altruistic suicide, exemplified by the captain's going down with his ship or the chaplains of World War II fame giving up their life belts. This is one of the more controversial of Durkheim's theories.

Aside from his theoretical formulations, the basic importance of Durkheim's work rests on two facts—the solid body of data

he collected, which served as a model for future demographic work in this field, and the stimulus he gave to formulation of etiological theories of suicide.

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WALTER E. BARTON, M.D.*

Care and treatment of the hospitalized mentally ill

In any period of great change, the major barrier to achievement of progress is the basic one of creating an awareness of the need to change. The old ways of doing things are familiar and comfortable. The accumulated experience of years weights the balance in favor of the proven response patterns. Today's problems can't be successfully managed with yesterday's solutions.

The care of the hospitalized mentally ill is changing rapidly. The large state hospital is usually located at a distance from major cities. Behind its wall or fence are shaded walks and attractive grounds. Usually there are acres of good farm land and prize dairy herds. Many of the buildings were built during the Victorian age and are uniformly unattractive

and grim, if not ugly. There are barred windows and grilled porches, gates and many locked doors. Wards are sparsely furnished with rows of swaybacked cots and "mission" rockers or sturdy benches. Masses of patients are bathed together without privacy and are herded to huge noisy cafeterias and are regimented into marching columns to go for a bit of a walk.

There are many things wrong with this model of the public mental hospital. It was more appropriate in another period of

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history when it was believed that rest and isolation from the family were good for one. Security measures were stressed as essential in the management of all mentally ill. Today we complain of the mental hospital's bigness—we want it smaller; of its location—we want it close to the community. High on the list of priorities is the small ward that encourages group living and interaction with staff. The huge barn-like wards, facilities for mass bathing and eating and buildings sprawled over acres of ground are not suited to today's purposes. There is much waste, too, because of inefficient arrangement and scarce professional manpower.

The large mental hospital has so many defects that some have stated it would be more sensible to abandon it and build new facilities where they are needed. Legislative bodies, sensitive to the high cost of the care of the mentally ill, are eager to follow the advice to stop spending money on the mental hospital. There is little indication of eagerness to support new facilities until they have demonstrated their usefulness. There are some most undesirable consequences developing from the lack of conviction that the state hospital is essential in today's psychiatric treatment plan. The blow to status of state hospital psychiatrists is a severe one. The only important aspect of psychiatry is seen as an office practice of psychotherapy for patients with neuroses. Few able men are being recruited for careers in hospital psychiatry.

If there is no need for the mental hospital, where does the schizophrenic patient go for help when the out-patient clinic treats only minor illnesses? What happens to the excited and noisy patient who is disturbing to others in the general hospital when drugs fail to quiet him? If 75% of acute mental cases recover in 60 days, what

happens to the 25% who fail to improve? What plan does society have for the care of the individual who is over 65 who has a major mental illness? Because these classes of patients do need care and because mental illness is still a major chronic disease, there is a continuing need for the mental hospital.

Private Practice—Community Mental Health Service—General Hospital—Mental Hospital, provide treatment in depth for those with mental illness. The great change that is occurring results from the mental hospital's active involvement in the development of community resources for psychiatric treatment.

Let us look at a few of the principles upon which the treatment of the hospitalized mentally ill is based today to discover the reason for the great change in the practice of psychiatry, and then let us look briefly at the program of patient care that has evolved to implement the principles.

PRINCIPLES

Early intensive treatment of acute mental illness results in a higher proportion of patients released from the hospital and a shorter period of hospitalization. Small crises, when dealt with promptly, may prevent rupture of relationships and extrusion of the one who is mentally ill. A few days in the hospital may ease the strain on patient and family so that both may be willing to work at stable, long range solutions. Families participate in emotional crises of a member; as a consequence, therapy is extended to involve key members. When major symptoms of mental illness are promptly treated, tensions are reduced and social behavior tends to reach expectations of hospital staff.

Chronic mental patients can be motivated toward a more active social role. Mental illness often is expressed in a with-

drawal from participation with others. Hospitalization may extend isolation and foster regression. The primary motivating forces, toward a more active social participation, derive from the warmth, sincerity and interest of staff in the patient. Interpersonal relationships form the basis for the catalytic process to promote social interaction. To leave the hospital, the chronic mental patient must give up a stable adjustment and security for an uncertain future. Problems of earning a living, family relationships, indifference and loneliness, or a bitter welcome in the community, reactivate anxiety when the step is taken from hospital back to living in the city.

Respect for mental patients and recognition of the right of each individual to human dignity and as much responsibility for himself as he can manage is another base for change in attitude toward the hospitalized mentally ill patient. Some of the key words and phrases that reflect this approach toward building an individual's self esteem and self confidence are voluntary admissions, retention of symbols of identification, a structured activities program with patient participation in planning, sharing in policy making, learning to accept greater responsibility for self management, the open door, pay for work done, expectation of return to the community, preparation for a job and assistance after leaving the hospital to maintain gains and move on to greater self realization.

PROGRAM

COMMUNITY PSYCHIATRIC SERVICES

For over thirty years there has been a gradual growth of psychiatric resources for diagnosis and treatment of mental illness in the community. As public acceptance

has extended, as more psychiatrists have entered into private practice and as more doctors and other professional groups have learned to cope with emotional and psychological symptoms, there has been an acceleration toward greater use of community facilities for patients who would have been mental-hospital destined only a short time ago. To be sure this trend has been most apparent in the large metropolitan areas where over half of all the psychiatrists reside (1). The success of community psychiatric programs in England (2, 3, 4, 5) and Holland (6, 7) and elsewhere (8, 9) forecasts the wider use of this approach in the United States in the immediate future. The stimulation of the National Mental Health Act of 1946 to the growth of community resources for mental illness has been a primary factor in the speed of development. Recently, states such as California, Minnesota, New Jersey and New York, have passed legislation to encourage the development of community mental health programs (10). Since 1952 the states (exclusive of Federal grants) have increased their expenditures for community mental health services 350% (from 5.9 to 27 million) (11). Mental hospitals are presently usually located at some distance from the urban areas that account for most admissions to the hospital.

The establishment of a Mental Health Center in the larger cities served by the remote mental hospital is a logical way to effect early treatment, to offset rising rates and to reduce overcrowding in mental hospitals. Some of the professional hospital staff may work half-time in the community psychiatric facilities, as they presently do in England.

The Mental Health Center facilities may include an out-patient department, a day hospital, and an emergency service that is prepared to visit the patient in the home

who can't or won't come to the center for evaluation and treatment. The Briggs Clinic of the Boston State Hospital, the adult out-patient facility, includes in its treatment cases psychotic patients who constitute about 16% of the case load. It is possible to increase the number of admissions to clinic treatment with major mental illnesses and make greater use of counselling resources for minor mental ailments (10).

The Boston State Hospital Home Treatment Service, a research project of the National Institute of Mental Health, appears to be able to treat in the community at least 40% of hospital destined patients (11). In this plan, when a psychiatric emergency develops in South Dorchester, the psychiatrist and social worker or nurse visit the home to make an evaluation and to initiate treatment. Some cases require immediate hospital care and this is arranged without delay. When a day hospital is available it makes possible a full day's treatment for additional patients who would otherwise have required in-patient management.

The number of general hospitals with psychiatric sections is increasing. The number of psychiatric patients admitted for diagnosis and short-term hospitalization is also increasing. A few general hospitals have found that some psychiatric patients can be cared for on general wards without special facilities.

A pilot project at Boston State Hospital tentatively showed that a very experienced staff of senior psychiatrist, head psychiatric social worker and psychiatric nurse could turn back from the hospital's admission section into community treatment, 10% of patients referred for in-patient care. Inexperienced psychiatric residents and intake staff lack the broad knowledge of community resources for treatment and the

prognostic skills to make proper referrals. It must be emphasized that this was not an attempt to turn away patients seeking admission, but only an expert evaluation of those patients who seemed capable of continuing to live outside the hospital if treatment could be made available in the community.

The most significant change in the management of major mental illness, therefore, is the development of local community resources for early treatment of patients who, lacking such facilities, would have been admitted to the mental hospital.

HOSPITALIZATION

Equal in importance to early treatment of patients with mental illness in the community is the application of the same principle to the management of the hospitalized person. Machinery is required for quick diagnosis. The cooperation of a highly skilled group of professionals and their technical assistants is required to arrive at a proper diagnosis just as it is in the general hospital. The ten or more days of emergency care or 30-day commitment for observation are legal designations only and no longer does treatment wait to begin until the end of an observation period. Therapy starts promptly for every patient and over half of those admitted are ready for discharge by the end of the 30-day period.

In 1945, the Boston State Hospital had 2,700 patients in residence, 1,150 admissions and 300 employees with 10 doctors. Fifteen years later, in 1959, it had 2,800 patients, 2,000 admissions, 1,000 employees and 40 psychiatrists. The rapid evaluation of admissions, successful treatment in a short stay in the hospital and a falling bed census requires more employees than we have and many more professional staff—nurses, social workers, psychologists and oc-

cupational therapists. The same needs are universally evident in state mental hospitals in this country. If every new patient admitted is to have the intensive treatment he deserves, personnel and resources for therapy are essential to that end.

The mental hospital with the primary objective to provide protective custody of patients and control of their deviant behavior could fulfill this mission in spite of large wards with many patients and with unskilled persons in attendance. When the primary aim is shifted to intensive treatment and prompt return of acutely ill patients to the community, different facilities are required and trained personnel becomes essential. An attendant can't develop social interaction in a ward of 60 psychotic individuals. Four persons trained in group work would have a difficult enough time to do so. Small wards of 25 patients make it easier to accomplish. Group therapy, drugs, electric shock therapy and an activities program require trained personnel. Training for attendants becomes imperative when there is an intensive treatment program.

Some chronic patients may also be returned to the community with intensive effort prolonged over one, two, or more years. A controlled study in rehabilitation at the Boston State Hospital in the pre-drug years showed no significant increase in release of patients worked with intensively as compared with controls. An unpublished study in action research (without controls) at the Vermont State Hospital shows 67 of 100 chronic schizophrenics returned to the community after intensive rehabilitation efforts; (95% received drug therapy.) Time does not permit more than brief mention of the rehabilitation process by which the chronic patient is helped to give up his security and dependency upon staff and hospital for the anxiety evoking

experience of living independently again in the community after years spent in the mental hospital.

Motivation toward recovery is supplied in corrective group experiences in a supportive environmental setting. Schedules and structured routines give way, after an initial period, to patient participation in planning their own work and recreational programs. The patients learn to accept responsibility for themselves and struggle—with many set backs—to live up to the expectations of the significant persons in their world.

"Job readiness" training helps them acquire social skills of punctuality, neatness, repression of objectionable ideas and intrusion upon the rights of others. Work in the hospital may develop old skills or new ones. It is my opinion that payment of patients for work performed will prove as effective a motivating force to greater participation in hospital industrial programs in the United States as it has in Europe where, even in poor countries, token payments for labor are made. At some stage the patient will be ready to move into a test of his ability to shift from patient status to that of employee. As a patient-employee, he may go on the payroll, handle his money, pay for his room and board and learn to think and feel as an employee. He may get a job in the community and return to the hospital only at night, or he may do piece work on a sub-contract in a factory in-hospital shop.

For the chronic patient, with years in hospital residence, a family care home or a half-way house may provide the strength for the first giant step back to self-sufficiency. Patients with families go home every Saturday and Sunday to learn to live again in the family group.

The patient social center may fill the need to belong to a group interested in him as

a person when he has neither family nor friends to help him in the lonely hours after a day's work is done. The friendly greeting, the warm inquiry that reflects sincere concern for the patient's welfare, and the chance to talk over problems to clarify next steps are but a few of the supports the social center offers to help patients moving toward greater self-realization.

The mental hospital's program for the patient returned to the community continues after he leaves; it provides what has come to be called "after care." Early release is possible when drug therapy is continued under supervision, individual psychotherapy and group therapy continue at night or on weekends even after the patient goes back to work. A few need a full day's treatment in the day hospital. This permits the patient to live at home earlier than he otherwise could do. An after care program to be effective must be available in the local community. We are fortunate at Boston State Hospital to be situated in the community we serve. Each staff doctor is expected to devote some of his time to after care of his own patients. When distance makes continued-treatment by the same psychiatrist impossible, a clinic or visiting nurse may serve to provide supervision and assistance to patients after release.

The presentation of an action program for mental hospital development evades some issues that must be faced to portray a true picture. Not all patients can be helped. Mental illness is essentially a chronic illness as is heart disease or arthritis. If one follows the health rules, he

may have a reasonably normal life with some handicaps. Relapses are not infrequent. Some patients require indefinite hospital care. Even among acute mental patients, from 20 to 40 percent require long-term hospitalization. Of those sent home, about one in three will return to the hospital again. Perhaps we have been over-concerned about relapses in mental illness for, in other chronic medical illnesses, we accept them as a symptom to be relieved without self-blame for failure of the therapy. Our public hospitals are filling up with old folks; aging chronic schizophrenic patients as well as those with mental illness associated with senescence. Only a third of the latter improve sufficiently to be able to live outside the hospital (most frequently in a nursing home).

WHAT MENTAL HEALTH ASSOCIATIONS CAN DO TO HELP

1. Recognize the need for change in the treatment program for the mentally ill.

The community process of discussion of problems creates the climate in which progress toward program development for the care of the mentally ill may occur.

2. Develop understanding by the public of the principles upon which the psychiatric treatment program are based and the reasons new facilities and programs are required and what they may be expected to accomplish.

3. Press for financial support of mental hospital treatment programs.

Cost of care per day

	115 YEARS AGO	1940	1959
Boston State Hospital	\$1	\$2	\$4.25
Massachusetts General Hospital	\$2	\$14	\$28.00

Dr. Harry C. Solomon recently made some comparisons in costs that illustrate the basis for the public mental hospitals' plight.

Rapid turnover of patients increases cost for diagnosis and laboratory procedures. Cooperative diagnostic teams of specialists are expensive. Intensive medical treatment of the aged is costly in nursing care. Medications are expensive and costly in nursing time, to administer and to observe for possible toxic effect. Intensive treatment and rehabilitation requires both facilities and trained personnel. With intensive therapy, each patient spends less time in the hospital on an admission and is returned to "taxpayer status" more promptly. Mental hospital bed census can be decreased in spite of increasing admissions and decreasing death rates.

4. Increase community tolerance for "minor" deviance. Open doors and increased privileges permit patients to explore adjacent streets and to test the hospital by going home without authority. The neighbors complain and threaten coercive action to prevent "dangerous characters from running loose." One woman expressed the layman's anxiety well, "I don't mind the women patients wandering through my yard in their queer clothes and sneakers but when an unshaven man with wild eyes pats my children on the head it frightens me. You never know what they will do."

As the doors of our mental hospitals open widely, more patients will leave the grounds before the hospital is ready to approve their release. Although most will be greatly helped toward self-management, some will abuse the privilege and cause community annoyance or even harm. Patients are people and act like people. Statistics assure us, though, they won't get into as much trouble—at least not in

criminal acts—as the normal people will (14).

5. Develop willingness in employers to hire former mental patients. Two hundred employers were interviewed (15) in an important study of attitudes toward former patients. About half of the employers were much concerned about violence or destruction and the effect of pressure and speed. Only 13% of employers knowingly hired a former mental patient during a three-year period. Ex-patients as a consequence learn not to disclose their history of illness and most are successful in getting a job. Positive attitudes about mental illness will be helpful in working through the acceptance of the worker by the employer on the basis of his productivity and capacity to get along on the job without causing disruption.

6. Increase local participation in the treatment program for the mentally ill through the development of

(1) Local community psychiatric facilities—O.P.D.—day hospital—emergency services—and general hospital beds.

(2) After care services for the returned mental patient through integration of available community resources for this purpose.

(3) New facilities in support of therapy, such as a halfway house and patients' social center.

7. Give direct support to the public mental hospital in three ways: organize volunteers, local planning groups and legislative committees.

The entire citizens' mental health group can perform a valuable service to the public mental hospital in its area by developing a reliable source for assistance in the development of a volunteer program. It can assist in recruiting, training volun-

teers, recognition of their service and in providing a forum for communication and program development by Directors of Hospital Volunteer Services.

Local planning groups, organized from leaders of volunteer groups, civic groups and service organizations, may be formed to give their collective support to the development of the psychiatric program of the local mental hospital. The community mental health center or a patient's social center can turn from a dream for the future to today's reality if a group of citizens begin to press for it and work for it.

Legislative committees formed within the mental health association are important aids to press for support of new programs and new local facilities for psychiatric treatment. "The hospital grandfather built and a little less money than last year—because money is tight this year" won't do to meet the needs for new facilities and new programs. The people spend what they believe is necessary—billions for farm support or highways. Resources exist for support of education or health if the public insists it wants it. Citizens are the essential ingredient in the organization of community support of a program to increase Government assistance to the public mental hospital.

For fifty years the Mental Health Associations have been active in their support of improved care and treatment of the mentally ill. The Council of State Governments has helped states increase their financial support of psychiatric services. The National Committee against Mental Illness has helped popularize the facts about mental illness and has secured more research funds. The studies of the Joint Commission on Mental Illness and Health will also help focus public opinion upon the problem areas in psychiatry. If im-

provement in the care and treatment of the mentally ill is to be achieved, it will be through the combined efforts of the professional person in the psychiatric field, working together with the citizens' mental health movement. It is time for change. Community support to make change possible is essential.

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Book Reviews

NEW FRONTIERS IN CHILD GUIDANCE

Edited by Aaron H. Esman

New York, International Universities Press, 1958. 218 pp.

This collection of papers from the staff of the Jewish Board of Guardians is essential reading for all disciplines and especially for every child psychiatrist, whether or not in child guidance clinic work.

Leah Levinger, chief psychologist of the Jewish Board of Guardians, has written a most interesting practical guide to the interpretations of psychological test findings for parents. There are many practical hints and suggestions that psychologists may well heed. Dr. Joachim Flescher has a thought-provoking paper on "The 'Dual Method' in Analytic Psychotherapy." He describes how the patient is simultaneously and alternately treated by two therapists, one of each sex, so that the therapeutic set-up closely approximates the parental situation. The oedipal situation nuclear to every mental disorder involves both parents. Dr. Flescher lists the benefits to be derived from the alternate contact with two therapists and discusses the possible objections that might confuse the patient. The results obtained are "sufficiently encouraging to warrant the application of the proposed technique on a broader scale." Certainly, new therapeutic methods should be researched, even if the practical, everyday application is far off and fraught with many realistic difficulties. Leslie Rosenthal, a group therapist, ably discusses the interrelationships among the activity group, group therapist, and supervisor. Many questions are raised, and there simply isn't space enough here to discuss them.

A second section presents some of the contributions to special techniques in child

guidance practice. If you are planning a residential treatment set-up for severely disturbed adolescents, then the paper by Marvin Scherer and his associates would be of much interest. Jerome Goldsmith's paper on clinical group work at Hawthorne Cedar Knolls School is interesting.

The reviewer is a director of a child guidance clinic and a therapeutic type of nursery school. It was with special interest, therefore, that I read of the use of the Child Development Center nursery school in diagnostic studies, for we have independently developed a program which is strikingly similar. Especially so, since "careful observation is essential to discriminate what is pathology from what is an inevitable developmental problem."

In a discussion of withdrawn children, L. Nagelberg, H. Spotnitz, and Y. Feldman present material seeming to demonstrate that emotional withdrawal is used by the unhealthy child as a substitute for an insufficient protective barrier against overstimulation. Dr. William Goldfarb and associates have written a fascinating paper on "Parental Perplexity and Childhood Confusion." We, too, have observed what is so clearly described, that "parents of the schizophrenic children in our care show an unusual relation to the schizophrenic child—parental perplexity." The special characteristics of these parents are discussed—that is, passivity, uncertainty, lack of spontaneity, lack of empathy. The authors point up what is often neglected: "The schizophrenic child requires an organized and directed environment, in an atmosphere of benevolent certainty." The last chapter of this collection of papers is an edited report of a clinical conference.

A stimulating, provocative group of papers. One may take issue with some of the points made, but the scholarship and

scientific zeal is of a high order.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

COMMON SENSE ABOUT GIFTED CHILDREN

By Willard Abraham

New York, Harper & Brothers, 1958. 268 pp.

The actual terms "mental health" and "mental hygiene" are hardly mentioned in this book of Dr. Abraham's, but the positive concepts of "health, peace, and happiness" run throughout it. The author uses, as he says, a personal approach—"to indicate that how long we live, how peacefully we get along, how pleasant our jobs and homes are, how healthfully our children are born and grow up, all of these are part of the tapestry of neglect and oversight of our gifted children."

Dr. Abraham's book is largely devoted to illustrations from actual school and community situations as to what is being done throughout the country for children who show giftedness of various types, at home or in the schools; who the teachers are and how they deal with the children; parents' attitudes, and the activities of such agencies as the National Merit Scholarship Corporation and the Ford Foundation. For next steps in helping the gifted the author believes that "it is the secondary school that is crying for help most desperately." Nursery schools in general give the most individualized attention based on the child's need, he says. Elementary schools have made a start. But "colleges are the slowest to change and will do so only if the institutions that feed them pave the way." He urges a plan in which industry would lend some of its key personnel to the secondary schools, these to have special speeded-up programs of teacher-education; a high school for gifted students

in every city of over 100,000 population; and a master plan at the secondary level all over the country to "mobilize our educational and industrial brains."—W. CARSON RYAN, M.D., University of North Carolina.

INTEGRATING THE APPROACHES TO MENTAL DISEASE:

Two Conferences Held under Auspices of Committee on Public Health of New York Academy of Medicine

Edited by H. D. Kruse, M.D.

New York, Harper & Brothers, 1957. 393 pp.

The editor's point of view is on the flyleaf: Multiple factors eventuate in degrees of health or sickness.

R. GERARD opens the discussion on etiology with "The Organic Position": In psychoses we deal with violins of bad construction and tuning, badly played.

C. LANDIS: On the other hand, the usual victim of delirium tremens comes of healthy stock and has imbibed large amounts of alcohol for years with impunity. He pushes his luck too far, adding fatigue, infection or trauma. His body and brain no longer tolerate the alcohol. Hallucinations and pain result, and then fright.

L. KUBIE gives "The Psychodynamic Position." Human "appetites" are only in small part biogenetic. Around every biogenetic need cluster the compulsive overdrives and phobic inhibitions of human psychopathology.

R. FELIX: Statistics tell us *what* happens, but not *why*. Communication and concept barriers must be confronted.

D. LINDSLEY: Aspects of nervous system function may tend to cause misinterpretation of outside signals. Factors in the nervous system may not limit intake of information; at other times factors on the response end, because of feedback, make it impossible

to interpret properly the kinds of stimulus settings in which the individual finds himself.

F. REDLICH: We psychoanalysts find it difficult to forget our narcissism and work with those of other work habits.

G. BISHOP: We (neurophysiologists) have to resign ourselves" not to talk about "a one-to-one correlation between neurological behavior and mental behavior . . . every bit of information must come into consciousness in code form . . . the neurology of mental behavior would be the study of unknown central activity in terms of the impulses that go into it and come out of it." (Later H. Jasper will say: For the biologist the stimulus patterns to which an organism reacts are as important as the patterns of nerve impulses they elicit.)

H. BROSIN mentions some interdisciplinary studies about the interaction of man's physical organism and adaptive mechanisms to his physical and conscious environment. For example, MIRSKY and co-workers have used excretion of pepsinogen in urine, uropepsin, as an index of the influence of various life situations on gastric secretion. Susceptible individuals might be detected long before disease appears. So called interdisciplinary work is highly charged; it is easy to lose one's identity, even to be destroyed.

At the second conference, B. F. SKINNER wants the experimental psychologist to observe the effect of genetic, organic and other variables on a base-line. Modes of behavior characteristic of mental disease may be simply the result of reinforcement, an unusual condition of deprivation or satiation. A developed experimental psychology (utilizing both learning theory and the conditioned reflex) is likely to produce behavior reflecting mental disease, and consequently change the behavior of the actually mentally diseased in the direction known as therapy.

K. W. SPENCE: The introspectionist as-

sumed a strict one-to-one relationship between verbal responses of his subjects and inner mental events. He accepted these introspective reports as facts, whereas the behavior scientist accepts the verbal response as just one more form of behavior.

ALEXANDER gives his version of the psychodynamic position: The ego is that part of the organism which gratifies subjective needs by coordinating them to each other and to existing environmental conditions. Whenever the ego is incapable of performing adjustment, conflict arises. Whether the conflict is internal or between the ego and environment, "some form of mental disturbance results." Schema for development of neuroses: precipitating factor→failure in solution of actual problems→regression→primary conflict revived by regression→self-punitive measures→tertiary conflict and impoverishment of the ego.

R. GRINKER disagrees: Causes of mental illness can only be viewed as many variables within a large field of events occurring in time. The principle of stability or homeostasis fails to consider those goal-changing forces which move the organism out of rest into new transactional fields.

T. RENNIE presents the psychosocial position: The best individual therapy can be defeated by the family unprepared for the recovering patient with new insights and greater freedom-demands. Many a schizophrenic is doomed to permanent hospitalization because families are too rejecting and unable to adjust to shifting relationships.

J. S. SCOTT goes further with "sociobiology": Animal experimentation on nonadaptive behavior suggests that three things are necessary: hyperexcitation of some kind, a situation in which it is impossible to adapt, and no possibility of escape. The factor of genetic differences could determine what is unbearable. In confinement, bears move around and develop stereotyped movements.

Cats, on the other hand, if well fed, will adjust in small cages.

At this point, editor Kruse is ready to look for areas of acceptance. Frequently an investigator working with one group of factors tends to neglect others. The first task is to identify all qualitative factors that enter into etiology. The second objective would be to devise methods to measure the proportional effect of each factor in each instance, for quantity, timing or amenability to control.

GRINKER: It would be easy to set up experimental designs mutually satisfactory to the organicist and the experimental psychologist or behaviorist, but not as yet to others. Observations on behavior over a segment of time will not enable even the physiologist to predict what an organism will do under other circumstances at other times. There are further areas of unacceptance among the participants. Until the psychoanalysts and psychodynamicists begin to speak less of instinct and libido and more of communication, without exchange of some fictional energy called "psychic energy," there will be steady divergence of opinion and methods of observation. *No one can put his finger on the most important factor in mental disease.*

J. FINESINGER: Sickness does not arise because of a conflict, but rather from the intensity of the conflict or the way of handling the conflict. In the social setting, those factors which make for stress and those which tend to relieve the stress make the difference between health and pathology.

GERARD: Most psychiatrists agree that organic factors in schizophrenia lead to anxiety and that what we see is a combination of organic and psychologic factors. As for experiments with babies, "We are not trying to measure love; we are trying to measure autonomic reaction . . . perhaps we could get an objective test of psychoanalytic dy-

namics. With the shift of the erotogenic zone from the mouth to the anus to the genitals, we would see whether autonomic responses from these regions occur at the predicted times."

E. WITTKOWER tells of an experiment based on the libido theory, with regressed schizophrenics who had been in the hospital 15 years. They were offered media corresponding to their level of regression (dirt to play with). They responded because of the attitude of understanding.

F. METTLER is agreeing when he says, "a good 10-cent fact is worth a vast deal more than a dollar hypothesis." He gives some accomplishments of the organicists: removal of the convulsive complex from the area of "sacred disease"; removal of dementia paralytica from the area of sexual excess, with proof of an infectious basis; elucidation of how the nervous system acts under drugs, particularly hypnotics, soporifics, and anti-convulsants; development of a structural pathology and microchemistry of neuro-psychiatry.

SCOTT suggests a basic research in psychiatry: "Look for differences early in life in arousal and forms of excitement."

ALEXANDER agrees: To explain the patient's reaction, know his biological structure. Has he had a vulnerable cortico-adrenal system ever since birth? It could have been tested in his first reaction to any emotional stress situation.

WHITEHORN: Psychodynamic factors range wider than those intimately personal in the patient. Insight and verbalization have been vastly overrated in psychodynamic theory and in practice of therapy. *"We are tempted to reduce everything to behavior and control. Clinically the psychiatrist deals with people in distress."* . . . "Why did we not discuss such important therapeutic aids as insulin coma, EST, lobotomy, chlorpromazine, serpasil?"

In closing, GERARD comments on multi-causality: We all agree that there is more than one factor in mental disease, but it is not enough to recognize all factors. "We begin to be useful only when we can quantify them. The situation then becomes reproducible and meaningful. This kind of causality we all can work with . . . many phenomena are interrelated, feed back upon one another, and give a system which changes as a totality." *The system and the separate components can be analyzed.*—ESTHER SOMERFELD-ZISKIND, M.D., Los Angeles, Cal.

PHYSICIANS AND SCHOOLS

Report of the Sixth National Conference on Physicians and Schools: Marking A Decade of Progress Toward Fitness

Chicago, American Medical Association, 1958. 150 pp.

"There is a mental-emotional aspect to fitness, which consists of living comfortably with yourself and others, and being able to meet adequately the demands of life," says Group III in its summary of the discussions at the Highland Park Conference on Physicians and Schools, November 1957. "There are experiences in the everyday life of pupils," says the report, "that may bring out focal points of stress or strain—such as school entrance, leaving home for the first time, parent-child relations, teacher-child relations, peer relations, getting hurt in play, failure to be chosen for a team or group, and other childhood experiences."

The group accepted the following list of basic emotional needs: love; independence or individual autonomy (the individual in his own right); security; achievement (recognition, approval, success); faith (belief in God—something greater outside ourselves); sex—creative needs; guidance or examples in living; companionship. Teaching can

have a significant influence on all of these, it was declared, and teachers need to acquaint themselves with sources of information and helpfulness in this area of mental-emotional health.—W. CARSON RYAN, M.D., University of North Carolina.

FAMILY GUIDE TO TEENAGE HEALTH

By Edward T. Wilkes, M.D.

New York, Ronald Press, 1958. 244 pp.

The preface indicates what the reviewer thinks the book is: a practical manual on the health problems of individuals aged 12 to 20. It discusses normal growth, heredity, nutrition, endocrines, rates of maturity, and so on. There follow sections on basic nutritional factors, posture, athletics, smoking and drinking and, specifically, care of the skin, teeth, and menstrual hygiene. These topics occupy Parts I and II.

Part III takes up common disorders of the skin, such as acne; aspects of menstrual function, such as tension, lessened or increased flow; endocrine disorders, such as hyper- and hypo-thyroidism, gonadal deviation, breast care. This is followed by a discussion of headaches, eye and ear ailments, foot symptoms, and a brief chapter on certain major diseases, to wit: tuberculosis, heart ailments, epilepsy, and diabetes.

Part IV contains a forthright presentation of problems of early dating, crushes, petting, sex relations, and some consideration of the more obvious physical aspects of sex: venereal diseases, homosexuality, and so on.

A final chapter on the so-called emotional disturbances (anxiety, hostility, shyness, inferiority, dependence) leads into some succinct statements concerning maturity and a religious background.

This reviewer finds the book a valuable

and wholly delightful volume. Every page is filled with clear statements of points of view and fact without giving an impression of dogmatism. The experience of years provides a platform of confidence and sincerity and, therefore, the book is potentially very helpful. To turn to any one of a dozen topics and find in one or two minutes what an experienced pediatrician thinks is refreshing and stabilizing. Moreover the writing is clear and devoid of superfluous verbiage.

When the chapter on emotional disturbances is reached, one with views like this reviewer's is bound to raise a few questions. Does not the discussion imply some of these things to be abnormal, thus engendering anxiety in the parents and adolescents although in the vast majority of cases, they are part of the normal growth pattern needing control and limitation, but very seldom management as a psychiatric situation? However, the reviewer gladly makes settlement for a book which in his opinion is a veritable compendium of fact, experienced judgment and, in general, judicious appraisal. The book can well serve a need in the homes of adolescents and others who may have occasion to call on mature knowledge.—FORREST N. ANDERSON, M.D., Van Nuys, Cal.

THE ANALYSIS OF DREAMS

By Medard Boss

New York, Philosophical Library, 1957. 233 pp.

Books dealing with the analysis of dreams are generally oriented along clinical and therapeutic lines. This present volume is so only incidentally and secondarily. It is essentially an inquiry into the philosophic bias inherent in the structure of classical dream theory and the development of the author's existentialist point of view. His

thesis, easily stated, but less easily understood, is that we exist no less in dreams than we do in waking life. This statement recurs throughout the book, often in more elaborate form, but with no clearer or more precise elucidation of the meaning involved. The author is on much firmer ground in his plea for a greater concern with the phenomenology of dreaming. He is sharply critical of both Freud and Jung for what he considers to be their implicit derogation of the manifest content. He points out how the "natural scientific" bias of both of these pioneers led them away from a concern with the dream at the phenomenological level and involved them mainly in a concern with the dream as a form of symbolic expression. The author elaborates on this in his discussion of the objective approach of Freud, wherein the dream object or person signifies the actual object or person or the dreamer's relationship to it or him, and the subjective approach of Jung, wherein the dream object or person personifies an aspect of the dreamer's own subjectivity. In both instances, the manifest content is by-passed in favor of a greater focus upon that which is hidden (symbolized) by it. He accuses both Freud and Jung of indulging in an analysis of psychic existence through the separating of aspects of that existence, the labelling of the resultant parts, and ultimately the reifying of the labels. Each was forced to assume the existence of certain "forces" (the instincts of Freud, and the inferred archetypes of Jung) capable of reuniting that which had been arbitrarily separated.

Nor are the author's critical barbs limited to the proponents of classical dream theory. They extend to a number of other writers, mostly on the European scene. Fromm is the only American author considered, mainly in a derogatory vein. Writing in what at times comes close to a polemical

style, Dr. Boss does not spare his existentialist colleagues. He feels that Binswanger's efforts also fail to adhere to a consistent concern with the inherent characteristics of dream elements, and that instead these elements are still considered by him as representations of objects in the waking world.

The author asks the question: "What if there are no dream symbols at all?" He then proceeds to an analysis of a series of illustrative dreams on the assumption that the elements of the manifest content stand for nothing other than themselves, or, more precisely, that which they reveal rather than conceal or symbolize, and what they reveal are the relationships and attitudes characterizing the existence of the dreamer at that moment. The dream is not a mere hallucinatory image, but a meaningful form of existence during sleep. The author refers to this as the "being in" the situation without the gratuitous elements of disguise, camouflage, or wish-fulfillment. These ideas are best conveyed in the author's own words: "In our dreams we experience real physical facts: a thing is a real thing, an animal is a real animal, a man is a real man and a ghost is a real ghost. In our dreams we are in just as real a material world as in our waking life, and in both cases we express our individuality in our behavior and relationships with the objects and fellow beings around us" (p. 106). "We learnt that man when dreaming, no less than when awake, always exists in his relationships with things and people. We have learnt, indeed, that these relationships go to make up his entire existence. We also learnt that man can realize his existence in dreams just as in waking life, through the most varied relationships and attitudes" (p. 122).

It is precisely in this emphasis on the manifest content as an end in itself that the author makes both an original and a valuable contribution and where in some meas-

ure his views are not too widely disparate from the rising tide of interest in manifest content which has been a feature of the recent literature in this country. He stresses the need for removing the dream from the implicitly derogatory prejudgments rendered from the vantage point of the waking state and points the way to the effective understanding of the dream at its own concrete phenomenological level. One might ask at this point whether a more thorough-going phenomenological assault upon the problem of dreaming should not encompass a greater interest in the nature of sleep and the relationship of dreaming to sleeping. The recent studies on the association of rapid eye movements during sleep and dreaming, the studies on altered consciousness attendant upon sensory deprivation, and the studies on changes in the symbolic processes associated with diffuse brain damage all point to the significance of physiological factors in the understanding of both the form and content of altered states of consciousness. This is certainly true for the phenomenology of dream consciousness as compared with consciousness during the waking state. The author is concerned with this difference, but apparently seeks an explanation in purely psychological terms. He speaks of an altered mode of existence during sleep, but does not link this up with a consideration of real alterations in the needs of the sleeping individual or functional alterations in the brain milieu.

The lengthiest chapter is devoted to a discussion of telepathic, clairvoyant, and prophetic dreams. It is difficult to evaluate the author's espousal of what is still a scientifically unpopular cause. On the one hand, it is in keeping with his general boldness and courage in taking his cues from the empirical data rather than obscuring and losing such data in the haze of untenable

and misleading assumptions concerning our present state of knowledge. On the other hand, a certain naiveté is revealed in the arguments presented to buttress his point of view—for example, arguing for the logic of telepathy based on the "openness" of man's existence and the fact that at every moment man exists in and with the objects and people that surround him.

In summary, Dr. Boss has presented us with a fresh point of view concerning the nature of dreaming. The book is the work of a very experienced and sensitive therapist and represents a vigorous and original fusion of psychiatric and philosophic thought.—MONTAGUE ULLMAN, M.D., New York City.

SCHIZOPHRENIA

By Manfred Sakel

New York, Philosophical Library, 1958. 335 pp.

Because of its varied content, and the space devoted to the specific treatment-procedure for which the author is so well known, this book might more accurately be titled "Insulin Treatment of Schizophrenia" and subtitled "General Theoretical Considerations." The first half contains an admixture of the author's philosophy of life, his theories about mental illness in general and schizophrenia in particular, and his attempt to be both medical historian and critic. The latter part of the book describes Sakel's treatment discovery, and his hypotheses and speculations which grew out of the clinical observations of its effects. Essentially, he argues that his theorization about the origins of schizophrenia is justified by the patients' clinical reactions to insulin therapy.

Sakel believes schizophrenia to be the result of an "interference in the structure of the nerve cell" and that "this can be proven without a doubt by those trained in the Classical Insulin Shock Treatment" by ob-

serving the behavioral changes it produces. Elsewhere he says, "It can be assumed that the schizophrenic disease process is based entirely upon a physiological and communicative electro-ionic disturbance" because of the "proven" effectiveness of the physiological approach.

The first part of the book may prove of value to the non-psychiatrist. However, for the psychiatrist interested in the history of insulin treatment, if not in the theorization of its innovator, the latter half of the volume will be of most interest. Some readers may regret Sakel's having made such a comprehensive effort at the expense of his *forte*—a specialized clinical treatment at which he was so adept. It is to be hoped that the author's tendency to philosophize and criticize psychiatry unnecessarily will not detract from the value the book's readers will find in the detailed discussion of insulin treatment itself, and in the author's keen clinical ability.

A pioneer may be forgiven his partiality and bias even after 30 years. Time and experience will ultimately place insulin therapy and its discovery in proper perspective. In any event, the courage of the author will be respected.—ALEXANDER GRALNICK, M.D., High Point Hospital, Port Chester, N. Y.

BEYOND FREUD

By Camilla M. Anderson, M.D.

New York, Harper & Brothers, 1957. 282 pp.

In *Beyond Freud* Dr. Anderson offers a "new theory of behavior" which is at variance with her early training in Freudian terminology and orientation and which fills a "personal need to reconcile inconsistencies and contradictions between those concepts I had been taught and insights I later drew from my own observations."

She states that her system has been "arrived at independently" and hence is not

eclectic, although "some of the conclusions are comparable to those of, for example, Pavlov, Korzybski, Sullivan, Kirshnamurti, Horney, and others."

In effect, Doctor Anderson has written a highly personal credo. She is declarative, deeply inspirational, and unquestionably motivated by earnest religious feelings.

What is generally recognized as psychoanalysis is designated by Doctor Anderson as "Freudian theory." It is regrettable that her exposition of this system of psychology, nosology, and therapy is so sketchy and selective as to make it largely incorrect in many points. The only writing of Freud to which she refers in her bibliography is the Modern Library edition (1938). Unfortunately, too, she does not mention any of Freud's other fundamental contributions, nor those of other psychoanalysts.—SYDNEY G. MARGOLIN, M.D., University of Colorado Department of Medicine.

A PROCESS FOR EARLY IDENTIFICATION OF EMOTIONALLY DISTURBED CHILDREN

Prepared by Eli M. Bower

Sacramento, Cal., Bulletin of the California State Dept. of Education, 27, 1958. 111 pp.

This book reports the method and the results of a study, conducted by the Department of Education in the state of California, designed to identify emotionally disturbed children within the classroom setting. The procedures were carried out by teachers within the class routine. One of the purposes of the study was to determine whether a teacher-centered procedure conducted in the routine class setting could identify emotionally disturbed children. A series of factors was evaluated, including intelligence, achievement, socio-economic status, and social status in the classroom.

A group of children, who had been studied by a psychiatric clinical team and identified as presenting emotional disturbance, was selected. The children were in the fourth, fifth and sixth grades. Classes in which one or more of the designated children were enrolled were selected for the study. The teachers were not aware of the reasons for the selection of the classes. Data on nine factors on all of the pupils in each class were then assembled by the teacher.

The findings justify the following conclusions: Children's judgments of other children's personalities are surprisingly accurate and predictive. The teachers' judgments of emotional disturbance are very much like the judgments of clinicians. The differences between emotionally disturbed children and the others increased with each grade level.

The methods of the study and the findings are presented in a clear, reasonable and interesting manner. There is much that is informative about both the emotionally disturbed and the other children, and much that will be useful to those working in the psychiatric clinic and within the school. The book is recommended for all professional workers interested in children and is written so that the material is accessible to the lay reader.—J. FRANKLIN ROBINSON, M.D., Wilkes-Barre, Pa.

COUNSELING THE EMOTIONALLY DISTURBED

By C. H. Patterson

New York, Harper & Brothers, 1958. 458 pp.

It is somewhat ironic that a pragmatic society such as ours should have given so little attention to the rehabilitation needs of the largest disability group, the emotionally disabled. The default may be attributed partly to the stigma attached to this group, partly to the difficulty of working with it,

and partly to less than adequate appropriations for dealing with problems of health, welfare and education. Our national and state budgets reflect not only our fears and some of our anxieties, but also many of our values. Clearly, we have not begun to mobilize either our wealth or our intelligence in behalf of our ill.

In any case, Dr. Patterson in this book has attempted to help us come to terms with some long neglected rehabilitation needs of the emotionally disabled. And if we fail to provide more and better help to this group, the fault will not be his.

He has given us a solid book. It is well written, organized and balanced. He includes what is important and omits what is irrelevant. In all his discussion, he very humbly admits what is not known or what is dubiously known.

Patterson begins with a definition of the nature and extent of the problem. He then proceeds to discuss the training requirements of the counselor, along with a substantial (and properly so) treatment of the counseling process. Despite his anchorage in an academic environment, he enters the market place and realistically details the problems of training and employment. In addition, he provides the reader with an excellent and up-to-date bibliography.

Some of my points of criticism of this book are:

- 1) The author could have given more attention to class and ethnic factors which might lead to a better understanding of the client.

- 2) He could have focused more on clients' needs as a pattern and so avoid the perpetuation of the present practice of viewing vocational needs in rather narrow and disconnected terms.

- 3) The author tends to view the client and his environment in interactional terms (like colliding billiard balls) rather than

transactionally; that is, with the client and the environment undergoing changes in whatever process he may be engaged in. This general tendency of viewing persons interactionally may account for much of the futility of trying to match traits against jobs as if they were unchanging "givens."

- 4) He maintains the widely held view that "the greatest problem in the placement of the emotionally disabled is the attitude of the public, and the employer in particular, toward this group." This seems to be little more than an assumption, which is discrepant with the author's own argument. On the one hand, the author contends that many of the emotionally disabled make poor workers; and on the other hand, he criticizes employers for rejecting them. The issue is: are the emotionally disabled rejected because of employer attitudes or because they are "poor workers"? Is there any evidence that those emotionally ill *able to work* are unable to secure work?

The reviewer recommends this book to all those professionals working with the emotionally disabled. Even those working with the physically disabled will find it more useful than many of the books that focus exclusively on them.—SIMON OLSHANSKY, Joint Commission on Mental Illness and Health, Cambridge, Mass.

DISCUSSIONS ON CHILD DEVELOPMENT, The Third Meeting of the World Health Organization Study Group on the Psychobiological Development of the Child, London 1955

Edited by J. M. Tanner and Bärbel Inhelder

New York, International Universities Press, 1958. 223 pp.

This volume presents the transcript of conversations focused on two topics: the development of sex differences in psychologi-

cal characteristics and the development of individuality, or ego-identity.

To open discussions on the first topic Margaret Mead presented comparative data from different societies to suggest the extent to which sex differences were determined by nature or by nurture. Erik Erikson introduced the second topic by discussion of his findings concerning sex differences in the play constructions of adolescents. The lively interchange in these groups successfully prevented all semblance of formal papers but did not interfere with orderly consideration of the topics. There were lively differences of opinion—as for example, Zazzo's encounters with the psychoanalytic viewpoint, or the psychologists' criticism of extending by analogy to human behavior ethological observations made on animals; nevertheless there was an exceedingly good-natured and insightful interchange of ideas. The book consequently makes very interesting reading.

Attending the discussions were Dr. John Bowlby, Dr. Raymond Saussure, and Professor Erik Erikson, for psychoanalysis; Professor G. R. Hargreaves and Dr. B. Buckle for psychiatry; Professors Jean Piaget, Barbel Inhelder, and Rene Zazzo for psychology. Representing electrophysiology were Drs. Karl-Axel Melin, A. Remond, W. Grey Walter and Professor Marcelle Monnier. Completing the group were Dr. Konrad Lorenz, ethology; Julian Huxley and J. M. Tanner, biology; Margaret Mead, cultural anthropology; and Frank Fremont-Smith, the general field of research promotion.

Margaret Mead's remarks betray a greater willingness than in earlier writings to consider that behavioral differences between the sexes may be the result of enhancement, through learning, of biological differences, both in structure and in energy mobilization and use. A number of interesting ex-

amples were given of how seemingly minor differences in structure may lead to rather extensive differentiation in behavior. Erikson's block constructions are fascinating (fortunately the text furnishes many illustrations), and clearly intrigued the discussants, but his presentation is most clear and convincing when he expounds his dynamic, developmental view of the psycho-social nature of children.

The discussions are valuable to developmental theory. Both major themes illustrate the principle of cumulation of effect in developmental process over time. Biologists present repeatedly drew attention to the importance of trends as contrasted with incidents and in demonstrating relationships, and by analogy to evolutionary processes also remarked how psychological patterns, adaptive at one stage of development, can carry forward into succeeding stages where they may not be so clearly adaptive. *Epigenesis*, the emergence of novelty in development, was noted in Erikson's analysis of psychosocial development. Conversely, social anthropology observed how such developmental change in the "nature" of the child affects the socializing impact of experiences provided by the culture. Mead shows how sex roles are conditioned by differing patterns of adult behavior toward children; Erikson establishes a theoretical rationale for the development of sex-roles, at least for European-American culture.

Among the many contributions of other participants, Huxley's concept of the open social system which permits the development of the "open" individual is timely. This material will be of interest to all concerned with personality theory and with concepts and problems of development, whether physical, psychological, or social. —DALE B. HARRIS, Institute of Child Development and Welfare, University of Minnesota.

GUIDANCE IN ELEMENTARY EDUCATION: A CASE BOOK

Edited by Esther Lloyd-Jones,
Ruth Barry and Beverly Wolf

New York, Bureau of Publications, Teachers College, Columbia University, 1958. 118 pp.

This is an unusual publication, and published at a time when there is a great need for both information and concrete help in thinking through the problems of elementary school guidance programs.

The first chapter in the book presents a clear, concise statement of various concepts of guidance; also how guidance in the elementary schools differs from guidance of students in other levels. The second chapter provides a very lucid and condensed discussion of the case study method. In a very few pages it sums up the importance of this particular method. These two chapters deserve very careful reading.

The balance of the book includes 25 case studies, each one written so that the attention of the reader is immediately caught, and his thinking—about the problems in the case presented—greatly stimulated. Each case study is presented in a conversational style, in two or three pages, which could very easily be used and read aloud at a staff or group meeting. At the critical point the case study is ended, and a few questions are posed for study and discussion. These questions are particularly sharp and pointed, and are of such a character that no “yes” or “no” answers are possible; they are certain to provoke extensive discussion.

I believe that this is one of the best books so far produced for the purpose of helping teachers, supervisors, and guidance directors improve and initiate guidance in the elementary schools. It is highly recommended for teachers’ meetings and conferences. Many of the discussions could be

used in PTA meetings to help interpret the school guidance program.—JENNELLE MOORHEAD, Oregon State System of Higher Education.

NEUROTIC DISTORTION OF THE CREATIVE PROCESS

By Lawrence S. Kubie, M.D.

Lawrence, Kan., University of Kansas Press, 1958. 151 pp.

This is a thoughtful and carefully written little volume which merits reference use and availability to all who would study the effects of neurotic influences on human creativity. Emotional illness is not necessary to creative endeavor. The understanding and relief of neurotic symptoms or of neurotic character traits through psychotherapy and analysis do not hamper or end one’s creative processes. Instead one finds that new freedom and a more clear direction is achieved. Neurotic forces are far more likely to distort or blindly drive one’s creative efforts.

Dr. Kubie points out the relation between free association, “the natural process by which man creates” regardless of his occupation or profession, and creativity. Unconscious forces often operate at cross purposes to what might obtain were one really free to recognize and to accept the promptings of pre-conscious processes.

The book is organized in four chapters, with some material borrowed and expanded from prior publications of the author. Those who have enjoyed reading others of Dr. Kubie’s works can expect to profit from this one also. Following a short discussion of the psychodynamics of neuroses and creativity, the author delves into the interactions between creative and neurotogenic processes. His points are carefully developed and amply illustrated with case ma-

terial which is interesting in itself. Following a good discussion of some applications for education generally, Dr. Kubie's closing chapter briefly and succinctly summarizes his thesis.—HENRY P. LAUGHLIN, M.D., Chevy Chase, Md.

THE ALIVE AND GROWING TEACHER

By Clark E. Moustakas

New York, Philosophical Library, 1959. 157 pp.

That teachers struggling with professional and personal problems can be helped to achieve healthy self-realization, mutual understanding, and a growing sense of self-education through open group discussion, is the thesis of this little philosophical volume. The writer, for 10 years a psychologist at the Merrill-Palmer School in Detroit, is concerned with the growth of the self. "Every experience in which the individual expresses himself in a free, spontaneous manner contributes to the growth of the self. As long as the person maintains the integrity and uniqueness of his individual nature, growth of the self, which begins at birth, continues throughout life."

His own experience in leading such a group has been used to document his point. "In an atmosphere of freedom and trust where individuals are valued, fully accepted and respected, a group of learners becomes its own best resource and serves as the primary basis for emerging insights and the resolution of problems." The fervent tone of the writing indicates the writer's deep conviction about his working concepts, concepts well corroborated by many psychologists, educators, and theologians. There can be only commendation for what he is trying to pass along.

On the other hand, if the special value of

this book is in its first-hand experience, the written account of the process involved is too sketchy and superficial to be as completely useful to fellow educators as it might be. For example, Chapter 3, "The Teacher's Expression of Self in Relations with Other Teachers," goes into a discussion among school persons without any description of the group—its nature, size, process, or even who are the teachers, principal, or other participants.

Also, the leader's procedure of applying total acceptance of teachers' statements sometimes results in his seeming to acquiesce in some questionable, fuzzy conclusions, such as a teacher's decision not to discuss with the mother of a troubled child the fact that the child cannot write and is disliked by all his classmates; the group's belief that a child should never be taken from one teacher and given to another; the group's failure to discern whether a particular child "doing nothing for five hours" is expressing satisfaction in sheer being or is in need of special help from his teacher.

The book is weakest where it is fragmented, interpreting quick shifts in teachers' verbal expressions as manifestations of deeper changes. It is best where it digs in: in Chapter 7, "A Return to the Self: Mrs. Allen's Experience" and Chapter 8, "The Teacher Becomes A Learner," in which the writer shares his own reactions to group sessions.

At a time when teachers are troubled by many self-doubts and conflicts about educational practices, constructive efforts to reinforce and accept teachers should be valued and understood. What the author has done for teachers has meaning for other school groups. It is to be hoped that he will go on to stronger, more detailed delineation of the process in his future writings.—EVELYN D. ALDERBLUM, School of Education, New York University.

Notes and Comments

NAMH AND AFFILIATES MAKE PLANS FOR MAY FUND-RAISING, FRIENDSHIP CAMPAIGNS

"Next—Let's Conquer Mental Illness" is the theme of the 1960 Bell Ringer Campaign for Mental Health. Launching ceremonies for the campaign will be conducted by the NAMH and its state and local affiliates during Mental Health Week, May 1-7.

Closely related to the "Let's Conquer Mental Illness Next" slogan is another—"Give at the Sign of the Ringing Bell." This slogan directs attention to the ringing mental health bell, the "trade mark" of the NAMH and its affiliates.

A third feature of the 1960 campaign is its overall title—"The 1960 Bell Ringer Campaign." Until this year, the term "Bell Ringer" was used only in referring to the door-to-door solicitation (the Bell Ringer March). From now on, the entire campaign (including the March, special events, business and professional solicitations and special gifts) will be referred to as "The Bell Ringer Campaign for Mental Health." The door-to-door solicitation will continue to be called "The Bell Ringer March for Mental Health."

* * *

"Operation Friendship," the successful project initiated last year to recruit 750,000 visitors to mental hospitals during Mental Health Week will take place again during 1960's Mental Health Week (May 1-7).

Invitations have gone out to more than 100 key national organizations asking that they participate in the observance. The goal this year is to double the number of mental hospital visitors with the help of

the invited organizations. Some of these are: the National Council of the YMCA's, the Salvation Army, the National Council of Catholic Men, the American Nurses' Association, the B'nai B'rith, the Boy Scouts, the Girl Scouts, the Camp Fire Girls, the National Grange, the Lions International, the 4-H Clubs, the Loyal Order of Moose, the General Federations of Women's Clubs, the Altrusa International, the Eagles, Kiwanis, Optimists, Pilot Clubs, Sertoma, Junior Chambers of Commerce, Elks, Knights of Columbus, Eastern Star, Rotary, Exchange Clubs, Business and Professional Women's Clubs, the American Legion, the VFW and their auxiliaries, and other prominent fraternal, social, charitable, and professional organizations.

Last year local branches of such organizations helped make Operation Friendship a success by arranging for bus caravans, motorcades, and other means of transporting visitors to the hospitals; many of these individuals traveled from 25 to 150 miles to participate.

The NAMH is directing and coordinating the 1960 Operation Friendship in cooperation with the National Institute of Mental Health and the state mental hospitals throughout the nation.

* * *

RESEARCH

The Western Interstate Commission for Higher Education has established a research advisory service in mental health for the West. This service, which is available to administrators and staff members of public institutions and agencies in the West, was established to "improve research designs and strengthen proposals through expert consultation."

The free consultation services, which in-

clude intensive review and critique of any mental health research proposal submitted, are available in research design, research administration, and evaluation of findings. The panel of advisers is headed by Dr. Leon J. Epstein, chief of research of the California Department of Mental Hygiene.

Anyone interested in additional information on this new service should contact Dr. Warren T. Vaughan, Jr., director of the Mental Health Training and Research Project, Western Interstate Commission for Higher Education, Fleming Law Building, Boulder, Colo. When applying for the research advisory service, he should outline his research proposal or protocol including: principal investigator, specific aims of study, research plan, prior investigations on topic, budget, and areas in which the research advisory service is requested.

* * *

The Veterans' Administration is conducting a 27-hospital study of the use of psychic energizing drugs against mental illness. The project is to determine whether psychic energizers added to treatment with the tranquilizing drug, chlorpromazine, will benefit apathetic, chronic patients with schizophrenia. The 16-week controlled, cooperative study involves some 500 long-hospitalized schizophrenic patients.

The four psychic energizing drugs being used are impramine, dextro-amphetamine, trifluoperazine, and isocarboxizid.

* * *

The VA is also conducting a many-sided psychological research program to analyze the individual age changes and resulting problems that occur as persons grow older. This program is under way at the Kecoughtan, Va., VA center. Among other matters,

the researchers are studying how the change from living in a small family unit to living in a VA domiciliary can be accomplished with a minimum of sacrifice of the aging veteran's individuality and how going away to a home for the aged affects men of advancing age.

More than 1,000 veteran-residents of the VA domiciliary home at the Kecoughtan center are the subjects of these studies.

* * *

A Boston researcher announced at the world's first International Medical Conference on Mental Retardation that as many as 10 per cent of the mentally retarded may be that way because of inherited body chemistry conditions.

Dr. Richard S. Paine, an associate in pediatrics at Boston's Children's Hospital and Harvard University, said that it was "virtually certain" these people might be helped if discovered in time, with accelerated progress in the field of biochemistry.

* * *

Three Mount Sinai Hospital (New York City) physicians reported in a recent article in the *Journal of the American Medical Association* that they believe psychiatric disturbances can occur in babies from the time of birth.

The psychiatrists, Drs. Myron L. Stein, Aaron R. Rausen, and Abram Blau, stated that "since a baby's range of behavior is limited, such psychiatric disturbances in infancy are more likely to be expressed as bodily complaints. Furthermore, evidence is accumulating that emotional trauma in infancy may be of critical significance in the development of later psychiatric disorders."

The doctors described a case in which an

eight-month-old baby's expulsion of food resulted from mental depression. On admission to the hospital, he appeared wasted, chronically ill, and unhappy. The psychiatrists diagnosed the problem as a reaction resulting from "infantile anxiety neurosis with depression."

Doctors interviewed the mother, found her to be depressed, and discovered that the baby's problem developed after the mother ceased giving him love and attention. After a special nurse assigned to the child gave him constant warmth and attention, he gradually ceased to regurgitate and gained weight. The mother was also treated through psychiatric interviews. Two and a half months after he was admitted, the child was discharged improved and developing normally; the mother continued to receive psychiatric help.

The authors of the *Journal* article stated that "psychiatric treatment of an infant must involve the mother as an integral part of the baby; when the mother cannot be involved directly in treatment, a mother-surrogate must be supplied since an infant cannot progress without a mother-child inter-relationship."

* * *

TRAINING

Directors of volunteer activities in many of the nation's mental hospitals attended their first national training institute in February in Topeka. This institute, which was sponsored by the NAMH, had as its purpose the advancement of the professional competence of these directors. Co-operating in the program were the Menninger Foundation and the Topeka State Hospital.

The volunteer directors attended seminars which provided broad surveys of

mental hospitals—their purposes and functions; they heard discussions on the care and treatment of patients, the role of the mental health association, public relations, a consideration of the community itself, and the operation of in-hospital volunteer programs including recruitment, training supervision, recognition for volunteers, and the development of administrative tools.

* * *

Volunteer services were also the subject of a two-day training workshop held by the Volunteer Services Council for the Texas State Hospitals and Special Schools in Austin. As part of this workshop a demonstration of the "remotivation" project for patients at Rusk State Hospital was conducted, moderated by Carl Sears, special services officer for the Houston VA Hospital.

Volunteers and hospital coordinators played the roles of patients participating in the small group discussions which try to get them back into contact with reality. Particularly aimed at the patient who has been hospitalized for a long time, the discussions at Rusk are actually led by psychiatric aids under the supervision of the nursing staff.

A climate of acceptance is established in which discussions about the ordinary world are used to encourage participation by the member patients. One of the Rusk staff members commented after the demonstration that "one of the best things about our remotivation program is that it remotivates the hospital employees, too, and gives them a greater interest and insight into their jobs." As more and more patients respond to the program, other state hospitals are planning to send representatives to Rusk to observe this use of group therapy on the wards.

* * *

A mental health institute for Major Superiors held at the College of St. Catherine in St. Paul, Minn., had as its theme the relationship between emotional and mental health and the moral and spiritual life.

The participants included general and provincial superiors and administrative assistants representing 32 congregations with members in 50 states. The combined memberships of these congregations is close to 27,000 Sisters who are associated with elementary and secondary schools, colleges, hospitals and nurses' training schools, and social welfare agencies.

The psychiatrists, psychologists, and sociologists who made up the Institute staff covered such subjects as the role of the unconscious, leadership, morale and mental health in religious communities, and a psychiatrist's view of authority.

Many of the Major Superiors who attended the Institute are setting up similar workshops for their local Superiors to extend the benefits of the St. Catherine's conference. A number of institutes have already been scheduled in California, Colorado, New York, Oregon, and the state of Washington.

* * *

Various state Councils on Psychiatric and Mental Health Nursing of the National League for Nursing have held demonstrations and workshops for their members in recent months. The California Council, during its state convention, heard a talk by John Gorton, NLN consultant, on "Education and Training of the Psychiatric Technician." Because California has recently passed legislation authorizing certification of psychiatric technicians under the Board of Vocational Nurse Examiners, emphasis in the talk was on pre-service preparation of the aide.

In a recent meeting held cooperatively with the state Department of Mental Health, the Connecticut Council discussed "Remotivation—Therapeutic for Patients or Staff?" Included was a demonstration with patients by William Ramsden, psychiatric aide instructor.

In Kansas, the Council and the Division of Institutional Management, State Board of Social Welfare, co-sponsored a workshop on psychiatric aide education. Participants came from psychiatric units of general hospitals, state mental hospitals, and private psychiatric hospitals.

* * *

The Western Interstate Commission for Higher Education has announced a new ten-week internship program in state institutions to introduce able Western college students to mental health work.

Colorado will serve as a pilot state for this first regional summer work-study program for 40 selected students from Western colleges as part of a four-hour credit course in sociology at the University of Colorado in Boulder. Participants will spend one week in intensive academic orientation at the University before going to job assignments. During the eight weeks on the job, a general seminar will meet weekly for continued academic work. The tenth week will be spent on the Boulder campus for additional academic work and evaluation.

As mental health interns in the Colorado Department of Institutions, the participants will be assigned as ward attendants, psychiatric aides, recreational aides, and occupational therapy aides in a participating institution. They will receive the salary paid for the grade—about \$280 per month or \$560 for the eight weeks—and the usual

conditions of employment will apply. Effort will be made to give interns varied experiences and an insight into the total operation of the institution.

Cost to the student will be \$44 for tuition plus room and board and transportation. Some fellowship assistance will be available to Colorado students from the Colorado Mental Health Association, and it is hoped that other state mental health associations will offer financial aid to students from their states.

Institutions participating in the summer work study program include the Colorado State Training School for the Retarded in Wheatridge, the Colorado Psychopathic Hospital, Denver General Hospital Psychiatric Unit, and the Colorado Children's Home, all in Denver, the Colorado Boys Industrial School in Golden, the State Training School for Girls in Morrison, and the Colorado State Hospital in Pueblo.

* * *

CARE AND TREATMENT

The director of California's Napa State Hospital has called the recent "therapy of fashion" conducted at his hospital "a revolutionary new development in the treatment of mental patients."

Dr. Theo K. Miller says he believes it may "become standard procedure for women mental patients in psychiatric hospitals throughout the nation."

The therapy he referred to was a fashion school conducted four Fridays by the San Francisco Association for Mental Health and the Fashion Group of San Francisco, an organization of leading women in the fashion world.

LEGISLATION

In a unanimous vote recently the Kansas Legislature passed a bill to provide \$895,000 for salary increases for psychiatric personnel in state mental hospitals and training schools.

This action, taken during the Legislature's annual between-session budget meeting) followed an intensive campaign by members of local mental health associations who had urged Kansas citizens to contact their local legislators to ask that they appropriate the increased funds.

The crisis which prompted this action arose last fall when a state commission on institutional management reported that the Kansas mental hospital training program was being threatened by resignations of training staff to comparable higher paying jobs in other states.

* * *

The American Legion, Department of West Virginia, took the lead recently in promoting a vigorous mental health campaign in the state. As part of this program, the state commander, Bonn Brown, organized a "legislative dinner" attended by members of the state legislature and the Board of Public Works to develop plans for a comprehensive mental health program in West Virginia.

Commander Brown has also appointed a new Joint Service Committee for Mental Health. This committee includes representatives from labor, industry, veterans' groups, parent-teacher organizations, the Legion Auxiliary, and medical and social service associations.

The New Jersey Association for Mental Health recently presented testimony to the state legislature urging legislative measures for better care and treatment of mental patients in the state.

This testimony asked that mechanical restraints not be used on any mental patient "unless required by his medical needs and ordered by his physician." The association also recommended measures to protect the dignity and civil rights of the mental patient including a recognition of his right to communicate by sealed mail with the authorities involved in his commitment.

The testimony included recommendations that "persons should be hospitalized within a reasonable geographic range of their homes, and that "the sole requirement for continued hospitalization should be medical evidence that this is in the best interest of the patient."

In addition to these recommendations, the state association has urged New Jersey Governor Robert Meyner to give top priority in his 1960-61 budget to appropriations directly related to improved care of the mentally-ill.

These priority appropriations include funds for the Bureau of Research to provide for continuing scientific investigations into mental illness, \$1 million for the support of mental health clinics, improved facilities for hospitals with a majority of patients over 65, special facilities for two children's units, appointment of a special services consultant responsible for developing recreational, educational, occupational therapy, and volunteer services programs, provisions for volunteer service assistants for hospitals, and the addition of enough personnel to permit increased use of the "open door policy."

An investigation by Georgia Governor Ernest Vandiver and a number of state legislators into conditions in the state mental hospital in Milledgeville has led to sweeping reforms in Georgia's mental health facilities. A newspaper series on the hospital prompted the legislators' visit to the hospital and led the Governor to appoint a committee of physicians, psychiatrists, and psychologists to further investigate the situation. A report issued by Dr. W. B. Shaefer, chairman, and the committee provides the basis for many of the new reforms.

Effective January 1, mental health and mental institutions in Georgia received additional support and emphasis in a major reorganization of the state Department of Health. One of the most important changes is the establishment of a new mental health unit to be directed by a psychiatrist who is directly responsible for supervising Milledgeville.

Dr. Irville H. MacKinnon, former clinical director of the Department of Psychiatry at Columbia University, has been appointed Milledgeville superintendent. The state is providing him with increased funds to recruit additional professional personnel, and plans are already underway to develop psychiatric facilities at the hospital and elsewhere. Also, a new intensive treatment program is being set up, as is a program of psychiatric training for medical students.

* * *

On the final day of its 1959 session, the Alabama Legislature passed a series of measures designed to upgrade mental health services in that state. The new legislation includes the following provisions:

Half the proceeds of a new 10 per cent

tax on liquor will be set aside for mental health services:

The Medical College of Alabama will receive \$220,000 to hospitalize and treat mental patients throughout the state, to strengthen its out-patient clinic and the training programs of its Department of Psychiatry, and to offer stipends to physicians who wish to enter psychiatric training.

* * *

The Mental Health Act of 1959 of the United Kingdom is a model which can be studied by other countries and by our own states. The detail of provision must, of course, differ from country to country and, for us, from state to state.

Still, the idea of reviewing all previous statutes and practices through an official commission and then drawing up a single comprehensive law to replace the previous patchwork, insuring the elimination of gaps and inconsistencies, is impressive.

The law itself is obtainable from the British Information Service, 45 Rockefeller Plaza, New York City. Cost is \$1.44 plus postage.

No better statement about this law can be given than that which appeared in the August 7, 1959, issue of *The Medical Officer*, 72-78 Fleet Street, London, E. C. 4, England. It has been the practice of MENTAL HYGIENE to serve as an archive for important documents. We offer the summary of *The Medical Officer* with this in view.

THE MENTAL HEALTH ACT, 1959

7th August, 1959

Summary of Main Provisions: The Next Steps

The Mental Health Bill received the Royal Assent on Wednesday, 29th July, 1959. Comprising 154 sections and 8 schedules, the Act paves the way for the repeal of the Lunacy and Mental Treat-

ment Acts, 1890-1930, and the Mental Deficiency Acts, 1919-1938, and provides for substantial changes on the lines recommended by the Royal Commission on the Law relating to Mental Illness and Mental Deficiency which reported in May, 1957.

A considerable number of amendments were made during the passage of the Bill through Parliament, in particular to the clauses dealing with the definitions of categories of patients, compulsory admission to hospital for observation or treatment, the composition and procedure of mental health review tribunals, the power to control patients' correspondence, and the periods of which authority to detain lapses if not renewed and at which patients may apply to a tribunal (the maximum periods were reduced to two years under the present law.)

The main principles remain unchanged. As the Minister of Health, Mr. Derek Walker-Smith, QC, stated during the Second Reading in the Commons, the two main principles are (1) that as much treatment as possible, both in the hospital and outside, should be given on a voluntary and informal basis, and (2) that proper provision should be made for that residual category of cases where compulsion is necessary, either in the interests of the patient or of society.

Main Feature of the Act

The main changes from the present law (which will come into operation on dates to be appointed by the Minister) are:

1. Single Code: New Terms. The single term "mental disorder" will be introduced to cover all forms of mental illness or disability, and there will be one legal code applied to all categories of patients instead of separate codes for the mentally ill and mentally deficient. Provisions for compulsory detention recognize four groups of mentally disordered patients—mentally ill, severely subnormal, subnormal, psychopathic.

2. No "Designated" Hospitals. The statutory limitation on the reception of "persons of unsound mind" and mental defectives in separately "designated" hospitals will come to an end. Hospital authorities will be able to arrange for treatment for any type of mental patient to be provided in any suitable hospital.

3. Informal Admission. All hospitals will be free to receive patients informally without powers of detention.

4. Powers of Detention and Safeguards. The procedure to be used when patients have to be detained compulsorily in the interests of their own health or safety, or for the protection of others, is completely revised and simplified. New safeguards against improper detention include Mental Health Review Tribunals to be set up in each of the 15 hospital regions. The tribunals will consist of legal, medical and lay members, and will have power to discharge detained patients from hospital or guardianship.

5. Protection of the Public. If a Court of Assize or Quarter Sessions considers it necessary for the protection of the public, it will be able to order that a mentally disordered person convicted before it or (in the case of Quarter Sessions) committed from a Magistrate's Court shall not be discharged without the Home Secretary's consent. While such a restriction is in force the patient will not have direct access to a Mental Health Review Tribunal, but the Home Secretary will be able to refer to the tribunals for advice at any time.

6. Board of Control. The Board of Control will be wound up. Some of its functions will be carried out by the new Review Tribunals, others by the local authorities and the Minister of Health. The three "special hospitals" (at present called "State Institutions")—Broadmoor, Rampton and Moss Side—will come under the direct management of the Minister of Health.

The Next Steps

The Act is likely to be brought into force in stages. The first action to be taken will probably be in the repeal of those parts of the Lunacy and Mental Treatment Acts which at present prevent designated mental hospitals from receiving patients informally. This will allow informal admission of patients to mental hospitals—and the decertification of any existing patients who can suitably remain on an informal basis—to start without waiting for the necessary preparations for repealing the whole of the existing Acts.

The Minister also intends, at an early stage, to issue a direction which will impose a duty on local health authorities to make arrangements for community care and after-care for all categories of mental patients, including the mentally ill. The authorities will then be asked to submit their proposals for these services within a period of, probably, six months.

The work of setting up the Mental Health Re-

view Tribunals and the preparation of the various rules and regulations required under the new Act, and of circulars of guidance for hospitals and local authorities on those aspects of the Act which they will have to administer, is likely to take some months to complete.

Mr. Walker-Smith, addressing the conference of the Association of Hospital Management Committees at Polkeston in June, gave two pledges on the implementation of the Act. First, there would be no avoidable delay. "We will press on with the administrative work with a will," he said. Secondly, there would be "skimping either of the administrative work of preparation or of the work of consultation which is so valuable."

• • •

The Federal Agency put into effect last fall new rules governing physical and mental requirements for airplane pilots and other members of flight crews.

Disqualification conditions include "A character or behavior disorder which is sufficiently severe to have repeatedly manifested itself by overt acts, a psychotic disorder, chronic alcoholism, drug addiction, epilepsy, or a disturbance of consciousness without satisfactory medical explanation of the cause."

MEETINGS

The 1960 NAMH Annual Meeting will take place November 17-19 at the Denver Hilton Hotel in Denver, Colo.

Site for the 1961 and 1962 annual meetings have also been announced. They will take place in Miami, Fla., and Las Vegas, Nev., respectively.

• • •

The Academy of Psychoanalysis will hold its annual meeting May 7 and 8 in Atlantic City, N. J.

Theme of the sessions which will be held

at the Hotel Claridge, will be "The Nature of the Therapeutic Process."

Drs. John A. P. Millet, New York City, and Robert G. Health, New Orleans, La., will be chairman of the morning and afternoon sessions, respectively, on May 7. Chairmen for May 8 are Drs. Leon Moses, New York City, and May E. Romm, Beverly Hills, Calif.

* * *

The American Society of Group Psychotherapy and Psychodrama has announced that its 19th annual meeting will be held at the Barbizon Plaza Hotel in New York City April 27-29, 1960.

* * *

The American Psychopathological Association held a symposium on the "Psychopathology of Aging" at its 50th annual meeting at the Park Sheraton Hotel in New York City in February. This symposium will be published in the course of the year.

* * *

The Academy of Religion and Mental Health held its first annual meeting in January in New York City. Dr. Francis J. Braceland, chief psychiatrist for the Institute of Living in Hartford, Conn., was chairman; he is a recent past president of the American Psychiatric Association, a charter member of the Academy, and member of its Advisory Council.

Anthropologist Margaret Mead was the guest speaker at a special luncheon session held jointly with the World Federation for Mental Health to inaugurate World Mental Health Year.

* * *

A community approach to the treatment of mental health is growing, and this trend must be nurtured by psychiatrists and other physicians working together more closely at the local level.

This was the theme of the discussions at the Conference of Mental Health Representatives of State Medical Associations, sponsored by the AMA's Council on Mental Health.

The 200 delegates were divided into six groups which tackled different facets of mental health.

GRANTS

A \$10,000 grant has been presented to the NAMH by the Smith, Kline and French Foundation for the Association's Personnel Development and Organizational Program.

Since 1955 Smith, Kline and French has contributed over \$100,000 to the Association for the development of field and program services.

PUBLIC INFORMATION

Howard Whitman, Westport, Conn., author and TV commentator, presented a one-hour live television report on the "Tensions of the Rat-Race Age" on Connecticut's Channel 5 recently.

Mr. Whitman, a founding member of the Westport Mental Health Association, is the winner of a 1957 NAMH television award. He was also awarded a citation in 1959 by the Connecticut Association for Mental Health for outstanding work done in the state fund drive.

* * *

A new series of mental health programs is now being televised in the Peoria, Ill., area. Titled "The Nation's Number One

Health Problem" and telecast by the local NBC affiliate WEEK-TV, the series concerns such subjects as: why is mental illness such an enormous problem; what can be done about it; what goes on in a mental hospital; how do we differentiate between personality disorders; what are the basic principles of mental health?

The series, which began in January, were prepared by the public information chairman of the Illinois Valley Mental Health Association.

* * *

The Advertising Council was the recent recipient of an NAMH citation presented for a "monumental job of dispelling public fear, stigma, and ignorance with regard to mental illness."

Lawrence J. Linck, executive vice president of the association, presented the citation to Advertising Council Theodore S. Repplier at a luncheon held in New York City. Dr. William Malamud, NAMH professional and research director, was principal speaker at the luncheon. His talk concerned the hopeful research outlook on the fight against mental illness.

The Advertising Council, which is responsible for coordinating the public service activities of the advertising, publishing, and broadcasting industries, has been conducting a campaign of public education on mental health since June, 1957.

More than 1,450,000 copies of the booklet "How to Deal with Your Tensions" were distributed to individuals who had requested the free pamphlet after hearing or seeing it offered in Advertising Council messages over television, radio, in newspapers, house magazines, and in transit advertising.

PUBLICATIONS

A report on state and local mental health and hospital programs has been issued and distributed to all NAMH affiliated state and local associations.

Titled "Fifteen Indices: An Aid to Reviewing State and Local Mental Health and Hospital Programs," the report was prepared by the Joint Information Service of the NAMH and the American Psychiatric Association. It contains valuable information for professional committees, hospital and clinic administrators, public health officials, and others involved in providing services for the treatment and prevention of mental illness.

This publication reveals a gradual improvement in hospital staffing and in expenditures for overall maintenance of the public mental hospitals; it also indicates that the number of full-time employees in these hospitals increased as did the amount of money spent daily for the care of each patient.

* * *

YOUTH FITNESS WEEK

"National Youth Fitness Week" will be May 1-7, the same period as Mental Health Week, according to a recent proclamation by President Eisenhower.

The president's proclamation urges "parents, young people, and interested national and local organizations to use all appropriate means now and during that week to promote programs and activities demonstrating the importance of youth fitness to the end that we may assure the continuing strength and well-being of our people."

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Notes and Comments

The work of the World Health Organization in the field of mental health

GENERAL INTRODUCTION

According to the Constitution of the World Health Organization, health is not simply the absence of disease but "a state of complete physical, mental and social well-being." It was natural, therefore, that a unit for mental health should be set up when the organization began its work. In January, 1949, this unit started functioning at the headquarters of the organization in Geneva. In the beginning, its staff was limited to one professional person. Since then, the staff has been slowly increasing. At present, two psychiatrists and a technical assistant work at headquarters; two psychiatrists have been attached as mental health advisers to the regional offices for Europe and the Eastern Mediterranean respectively, and a third regional adviser is about to be appointed in the regional office for the Americas (the organizational structure of which has been in existence since 1901 under the name of the Pan American Sanitary Bureau).

Apart from this permanent staff, the organization employs short-term consultants.

Some of these visit those member countries that desire to have the collaboration of international experts; they render assistance by surveying the existing organization of services and by offering technical advice on future developments. Others collaborate directly with the officers in charge of the mental health program of the organization, either at headquarters or in the regional offices. In certain cases, the organization also provides specialists, at the request of member governments, on a long-term basis. These are usually experts with a special competence in a specific field of mental health practice, and their function is to work alongside their local colleagues and to prepare their national counterparts for independent continuation of the activity in question.

There is a division of labor in the sense that the foremost task of the headquarters unit is the development and formulation

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of what might be termed the WHO policy in mental health matters, while the regional offices are normally responsible for the organization of field activities. This is the reason why the headquarters unit enjoys the help of yet another category of expert: the members of the Expert Advisory Panel on Mental Health. This panel comprises, at present, 70 experts from 35 countries; the participants of the periodic expert committee sessions are drawn from its ranks. This does not mean that the regional offices do not make use of expert advisers; as a matter of fact, they do quite frequently. Nor does it mean that only the members of the expert panel can be invited to meetings; there are study group meetings that deal with special types of problems and in which outside experts often cooperate. It is true, however, that the expert committee meetings are the main instrument of the organization in respect to policy development, and great care is taken, therefore, to make these meetings (usually limited to seven to nine members) as representative as possible, particularly from the point of view of the geographical and cultural distribution of the participants.

EXPERT COMMITTEE ON MENTAL HEALTH

Between 1949 and 1959, the Expert Committee on Mental Health held eight meetings, and since the reports of these meetings reflect the development of WHO's work in the mental health field particularly well, a short resumé is given below:

- (1) *First Expert Committee* (August 29–September 2, 1949)¹

In this meeting the Expert Committee set itself the goal of outlining an international

mental health program. The committee expressed its belief that "it will not be possible within the foreseeable future to provide throughout the world for all peoples therapeutic psychiatric facilities of the level already provided in the more developed countries" and it therefore put forward the opinion that "it is only by the preventive application of psychiatric knowledge that mental health problems can ultimately be solved." In connection with this, it stated that "the most important single long-term principle for the future work of WHO in the fostering of mental health is the encouragement of the incorporation into public health work of the responsibility of promoting the mental as well as the physical health of the community."

As a second principle the committee put forward "the desirability of concentrating especially on the therapeutic and preventive psychiatry of childhood." It gave a warning against "the automatic reproduction of methods and techniques evolved in other countries" instead of trying in each case "to reach methods of handling the problems appropriate to the local situation." With respect to the education of mental health workers, the committee recommended "the re-casting of undergraduate medical education to ensure that it gives to the undergraduate an understanding of normal psychological development and of the origin and nature of common psychological disorders equal to that which is already provided in the organic field." It emphasized "the importance of incorporating an understanding both of psychiatric nursing and of the psychological aspects of general nursing into the training of every general hospital nurse" and the equipment of public health nurses with sufficient knowledge to enable them "to contribute to preventive mental health work by the advice they give to parents on the handling

¹ *World Health Organization Technical Report Series*, 1950, No. 9.

of infants and children." The committee also emphasized the importance of adequate health education of the public and of well-planned and well-conducted research. Finally, it stressed the need to study such specific problems as alcoholism, drug addiction, exposure to venereal diseases, juvenile delinquency and others and made a number of suggestions as to ways of achieving this program, including reference to collaboration with other international governmental and non-governmental agencies.

(2) *Second Expert Committee* (September 11-16, 1950)²

In this meeting, the committee concentrated on the need to introduce mental hygiene into public health practice. It pointed out that psychiatry "developed as a personal service to the sick individual" and that "only recently . . . psychiatrists have attempted to contribute to preventive medicine." It felt that it is "incumbent on psychiatrists to recognize their responsibility to public health practice" and said that "the public health worker needs the support of the psychiatrist not only in handling those problems which are beyond his competence but also in integrating the principles of mental hygiene into his practice." From this point of view, the committee went into a detailed consideration of the mental health aspects that should be considered with respect to maternity services, the infant and the pre-school child, school health, the handicapped child, the management of communicable diseases, the care of the aged, health education of the public, and migration. It also referred to the need to develop health statistics with respect to mental disorders and to foster what in recent years has come to be called the "epidemiology" of psychiatric disorders. It paid attention to the mental health factor in the activities of public health

administrations and recommended the provision of systematic mental hygiene training for public health workers. With respect to this latter point, it stated two general principles: (a) "Mental hygiene training should aim at giving the public health worker a broad understanding of human behavior and should not consist of a formal course in psychiatry," and (b) "Such material as is presented will be more effective if it is integrated into the various established courses in the curriculum rather than given as a separate course."

(3) *Third Expert Committee* (November 24-29, 1952)³

At its third meeting, the committee analyzed the requirements of psychiatric hospitals, paying special attention to the necessity of keeping psychiatric institutions in the closest possible contact with the surrounding community. It gave a warning against the common belief that the psychiatric problems of a community could be solved by the provision of more and more hospital beds. With respect to this question, it stated that "probably any community will ultimately find it necessary to provide at least one psychiatric bed per 1000 of the population," adding that "once this level has been reached, however, it must not be assumed that the next step in the development of psychiatric services is to increase the number of psychiatric beds. It is probably preferable that the moment the provision of beds reaches this level, those responsible for planning psychiatric services should devote at least as much attention to the development of extra-mural treatment facilities and other psychiatric

² *World Health Organization Technical Report Series*, 1951, No. 31.

³ *World Health Organization Technical Report Series*, 1953, No. 73.

activities within the community side-by-side with any further increase in the provision of psychiatric beds. There is no doubt that in the past too much attention has been given to the mere provision of further psychiatric beds and too little to the development of a real community mental health service."

The committee then went into a detailed analysis of the steps which should be taken in the development of community mental health services. It stressed the importance of preventive and educational extra-mural activities and of the necessity of providing extra-mural treatment.

"Out-patient work," it said, "is the antenna of the community mental hospital and . . . from the clinical experience of this service may be derived the most reliable indicators of the direction in which the hospital should develop if it is to meet the needs of the community it serves." One organizational type that the committee recommended particularly was the "day hospital." It pointed out that "the day hospital may succeed in helping the recovery of various types of patients whom it was difficult to help until now," and described it as "a distinct and important addition to the means of treating psychiatric patients and one which every community mental hospital should consider establishing." With respect to the in-patient services of the community mental hospital, great stress was laid on the creation of a "therapeutic atmosphere." Among the elements necessary for this it mentioned: (a) the preservation of the patient's individuality; (b) the assumption that patients are trustworthy; (c) the assumption of the patients' capacity for a considerable degree of responsibility and initiative; and (d) an intense, planned, and purposeful activity.

With respect to treatment, the importance of social treatment was particularly stressed. The committee insisted on the formation of a true therapeutic team in which doctors, nurses, social workers, and others have an equally valid role. It expressed its belief that it is "undesirable to build new psychiatric hospitals for more than 1000 patients" and voiced the opinion that "the optimum capacity for a hospital probably lies between 250 and 400 beds." It expressed the view that a psychiatric hospital "should be situated in the immediate vicinity of the community it is to serve" and considered that if this condition were fulfilled, it might be preferable to the inclusion of psychiatric wards in general hospitals.

(4) *Fourth Expert Committee* (November 1-6, 1954)⁴

On this occasion, the committee considered the legislation affecting psychiatric treatment. After pointing out that the attitude of society towards the mental patient is changing, it criticized the legislation affecting the mentally ill that exists at present in many countries, outlined the essential requirements to be met by legislation, and paid special attention to the legislative aspects of the problem of the unwilling patient and of the organization of the psychiatric service. It discussed what kind of mental health act was needed and came to the conclusion that "a single mental health act covering both the mentally ill and the mentally sub-normal was the most useful form of legislation."

It said, furthermore: "Laws which set out in detail the kind of establishment to be set up or which lay down detailed provisions regarding the medical and nursing care of patients or the numbers of staff required are more likely to hinder than to assist the evolution of good psychiatric services. Such things are better left to regu-

⁴ *World Health Organization Technical Report Series*, 1955, No. 98.

lation, and the law should merely prescribe who should make the regulations and who should ensure that they are carried out." In connection with this specific problem, the committee again insisted on the need to apply the principles set out in accordance with the type of social structure which prevails in a country.

"What is required," it said, "is to give these patients facilities for treatment and the possibility of guardianship and medical supervision in accordance with their medical needs and social inadequacy. . . . No one system can be applicable to several different countries, and even in one and the same country, the systems advocated by some will be repudiated by others. Any system which comes into conflict with legal or cultural conceptions is inapplicable. It would seem, therefore, that preference should be given above all to establishing laws strongly integrated into cultural traditions while at the same time leaving the way open for possible changes."

(5) *Fifth Expert Committee* (December 10-15, 1956)⁵

In its fifth meeting, the Expert Committee took up a theme that had been introduced in the first session: the gap which, particularly in "well-developed" countries, often exists between strong therapeutic facilities and weak preventive services. It pointed out that this gap "should not be allowed to open where mental health care is still in its beginnings." Referring to the conclusions made in the third committee report, it expressed the view that "the psychiatric hospital is often the only place where systematic mental health work can be undertaken and where possibilities for further education and training in the mental health field exist" and then went on to examine "the conditions which will enable the psychiatric hospital service to carry out preventive work together with its curative

activities." In dealing with this subject, the committee studied the relationship between therapy and prevention and stated that "the development of mental hygiene is intimately linked to the advancement of psychiatric therapy not only because an effective early treatment of mental disorder can in itself be considered as preventive but even more because the progress of therapy helps . . . to create favorable conditions for positive prevention."

It examined in particular the significance of the "opening" of the psychiatric hospital for its preventive usefulness and indicated an "ideal structure of an integrated mental health service" with its possible variations. In this respect, it emphasized the desirability of providing as the "central structure of a mental health service," "a relatively small active treatment unit which could be provided with the necessary out-patient facilities and, in some parts, with mobile units." It compared this type of unit with the "long stay unit," to which it accorded a lower degree of priority. The committee referred extensively to the training of the psychiatric hospital team for preventive activities, emphasizing the value of team work and the need for retraining older personnel. It summed up by saying that "an adequately organized psychiatric hospital with its extensions into the social life of the community and firm links with the other branches of public health is the rational starting point and base camp for a truly efficient mental health service."

(6) *Sixth Expert Committee* (September 1-6, 1958)⁶

The sixth meeting of the Expert Committee was devoted to the special mental health

⁵ *World Health Organization Technical Report Series*, 1957, No. 134.

⁶ *World Health Organization Technical Report Series*, 1959, No. 171.

problems of aging and the aged. It set itself the task of examining first "the reinforcement of the mental health of the aged themselves" and secondly "the promotion of society's awareness of the needs and possibilities of its older members." In order to do this, the committee considered it "necessary to place the mental health problems of aging and the aged in their demographic, epidemiological, and medical setting." In this connection it paid particular attention to cultural and social differences with respect to the quantity and quality of the problems encountered. It studied socio-economic, psychological, psychopathological, and different types of physical factors and recommended measures from the point of view of social management, public health, and education. One of the main items considered was the organization of geriatric mental health services. It was stated that "the health problems of the aged can be solved only by a wide extension of facilities for care in the community." In particular it was pointed out that "an adequate community mental health service must have several lines of defense including comprehensive domiciliary provisions with home helps, social workers, health visitors, nurses and consultant psychiatrists, clubs with recreational facilities for the aged, sheltered workshops and residential accommodation of a warm, home-like character, as well as out-patient clinics, day hospitals and long- and short-stay annexes, and the mental hospital." Finally, the committee proposed a classification of mental disease in old age and commented in a detailed way on specific measures of treatment and rehabilitation and on the need for research on gerontology.

(7) *Seventh Expert Committee* (October 20-25, 1958)⁷

On this occasion, the Expert Committee re-examined the relations between psychiatric work and community life from a new angle. It pointed out that advances in psychiatric practice had led to the development of a more intense consideration of social factors in the causation as well as in the prevention and care of mental illness. It defined social psychiatry as referring "to the preventive and curative measures which are directed towards the fitting of the individual for a satisfactory and useful life in terms of his own social environment," and stated that "in order to achieve this goal the social psychiatrist attempts to provide opportunities for the mentally ill and for those in danger of becoming so for making contacts with society which are favorable to the maintenance or re-establishment of social adequacy." In this connection, the committee examined the attitudes of the community with a view toward fostering an increased cooperation between its members and the mental health personnel and formulated the problem in the following terms: "The psychiatrist is nowadays often able to place a person at the door through which he can set out into normal life, but this action will not have the desired effect if outside that door is only empty space. If society is to reap the full benefit of the advance of modern psychiatry, it must learn to collaborate in the prevention of mental disorder and in the therapy and rehabilitation of the mentally ill."

With this in mind, the committee examined in detail the different types of community attitudes and analyzed, in particular, the current concepts of mental illness and its origin, the prevailing notions of normality and abnormality and the atti-

⁷ *World Health Organization Technical Report Series*, 1959, No. 177.

tudes towards certain symptoms, the prognosis and the treatment of mental disorder. It also studied the reaction of the community to different clinical types such as psychotics, neurotics, psychopaths, the mentally subnormal, abnormal children, and abnormal persons of advanced age. Special attention was paid to the influence of different community structures and of certain community institutions, such as organized religion, law, and educational systems. The influence of age and education and of personality factors was examined, and the role of specific groups, such as patients' families, community leaders, employers, health personnel and the patients themselves, was reviewed. The committee then went into a detailed study of community attitudes towards psychiatric practices and psychiatric personnel. Here again, care was taken to contemplate different social and cultural situations as well as the existing types of psychiatric treatment. In its recommendations, the Committee advised an extension of active treatment and community care and referred in a detailed way to the content and methods of information and education and to the community groups which should be taken into account from this point of view. Reference was made in this respect to psychiatrists, psychologists, social scientists, general physicians, community health workers, different types of community leaders, and the families of the patients. The committee also made a series of recommendations on research, particularly with regard to systematic attitude research.

(8) *Eighth Expert Committee* (June 8-13, 1959)^s

At its first meeting, the Expert Committee had already stated that "an understanding of the true incidence of psychological dis-

orders" can only be obtained "by sampling studies." At its third meeting, the Committee returned to this topic and recommended that it would be necessary "to carry out . . . surveys of sample communities in order to arrive at a working estimate of psychiatric morbidity." It also mentioned that "apart from their practical value, comparative studies of the prevalence of psychiatric morbidity which compare that found in different communities, different social groups, and different cultural patterns are of very great theoretical importance, because they may well throw light on important etiological factors and thereby open the way to more effective prevention." In its eighth meeting, the committee concentrated on the task of studying the "epidemiology of mental disorders," i.e. "the study of their distribution and behavior under differing conditions of life in human communities." The committee lamented the fact that "no satisfactory solution has yet been reached" with respect to the provision of "a generally accepted system of statistical classification which allows data obtained by various investigators to be confidently compared." It commented upon the difficulties inherent in the International Statistical Classification of Diseases at present in use and pointed out the conditions which a satisfactory classification would have to fulfill. In this respect, it stressed that a future classification would have to observe "neutrality in the controversies between various schools of thought;" that "it must be a servant of international communication rather than its master," and that it should not try "to take the place of regional or local classifications which will often . . . advance knowledge." Particular attention was paid to

^s World Health Organization Technical Report Series, 1960, No. 185.

epidemiological method, which was mentioned with regard to operational and clinical studies. The conduct of field surveys are covered in considerable detail. There were recommendations particularly with respect to sampling and sampling methods, case-finding, standardization of psychiatric diagnoses, selection and definition of clinical terms, methods for covering data on individuals, screening devices, and the use of standard clinical case material. Reference was made to the possibility of using controlled experiments or of taking advantage of "experiments of opportunity." The committee examined in detail the problems of staffing for epidemiological work in psychiatry and made recommendations for training. There were, finally, many suggestions for research, both on methods and concepts and on operational and clinical problems.⁹

ADDITIONAL EXPERT COMMITTEES

It would not be appropriate to refer in this paper only to the expert committees which dealt with problems of general mental health interest. There were also others which examined more specific problems, often jointly with the expert committees of other units of the organization, or with other agencies of the United Nations family. The work done by these committees will be reviewed below.

(1) *Expert Committee on Psychiatric Nursing* (August 29–September 3, 1955)¹⁰

This expert committee, organized jointly by the nursing and the mental health sec-

tions of the organization, tried to find common elements and general principles that could be applied to the organization of nursing care in different areas. The committee recognized that "in every country psychiatric nursing practice is directly related to cultural attitudes toward the mentally ill and to the development of psychiatry and of nursing as a profession" and that therefore the methods will vary and fulfill the essential needs in succeeding stages according to the total facilities available. It pointed out, however, that the role of the psychiatric nurse was gradually changing in so far as a shift was taking place from "an 'inter-personal' concept of patient behavior to an 'intra-personal one'" and "from a custodial role to a therapeutic one." Accordingly, "the education of the nurse moves from the descriptive, didactic type of program to one which will provide her with more therapeutic skills in nursing her patients." "Understanding of personality growth and development, theories of human behavior, concepts of anxiety, sociological aspects of psychiatric care and group methods . . . begin to form an integral part of the educational and experiential background of the nurse."

The committee first examined in a detailed way the role of the psychiatric nurse with regard to the factors determining it and the different steps in its development within the mental hospital. It reviewed the essential nature of psychiatric nursing referring to patient care, supervision, community health activities, extra-mural activities, community care before and after hospitalization, and the special problems of general hospital and public health nurses. It then referred to the needs with respect to the education of psychiatric nursing personnel, paying special attention to methodology and recommending a basic curriculum. The committee finally made

⁹ It may be worth while mentioning that the Expert Committee will have two more meetings in 1960; the first will examine the undergraduate teaching of psychiatry and mental health promotion; the subject of the second will be program development in the mental health field.

¹⁰ *World Health Organization Technical Report Series*, 1956, No. 105.

recommendations with respect to research needs, particularly with regard to research in clinical nursing, nursing education, nursing administration, and the preventive aspects of psychiatric nursing.

(2) *First Meeting of the Alcohol Sub-Committee* (December 11-16, 1950)¹¹

This sub-committee of the Expert Committee on Mental Health approached alcoholism as a disease and as a social problem. It expressed the view that the public health services could and should make extensive contributions, but that legal or social measures related to the distribution and use of alcohol were also of considerable value. It pointed out that alcoholism is likely to pass through a series of stages which it described as symptomatic drinking, addictive drinking, and alcoholic deterioration. With respect to the incidence of alcoholism, it recommended the use of the so-called "Jellinek formula" which is said to allow the determination of the size of the alcohol problem in terms of the incidence of liver cirrhosis and the mortality therefrom. As to treatment, the committee referred to facilities and means, and in the latter respect, expressed its belief in the efficacy of pharmacological treatment by Disulfiram. Finally, the committee made some remarks on the education and training of health workers with regard to alcoholism and the value of cooperation with such voluntary organizations as "Alcoholics Anonymous."

(3) *Second Meeting of the Alcohol Sub-Committee* (October 15-20, 1951)¹²

In its second meeting, the Alcohol Sub-Committee concentrated more on practical and specific aspects of the problem of alcoholism. Without prejudice to the preventive aspects of a program, the committee

felt that "progress in the various phases of the problem of alcoholism is most feasible only after the large number of alcoholics throughout the world has been considerably diminished through a large scale rehabilitation effort." Referring again to the different stages of alcoholism, the committee examined the existing treatment facilities and went into a detailed discussion of the treatment by Disulfiram. The committee further made some remarks about the statistics and the classification of alcoholism. An annex referring to statistics in the surveying of alcoholism and alcohol consumption was added to the report.

(4) *Expert Committee on Alcohol and Alcoholism* (September 27-October 2, 1954)¹³

This expert committee was organized jointly by the mental health section and the section on addiction-producing drugs which had convened an Expert Committee on Alcohol in 1953. This 1953 committee had reviewed the alcoholism problem from a more pharmacological point of view.¹⁴ In the expert committee under review, the psychiatric and the pharmacological approaches were taken into account side by side in order to facilitate "a direct exchange of experience among pharmacologists, physiologists, and psychiatrists as well as their agreement on the interpretation of some basic conceptions of alcoholism." One of the main topics of this session was the combined problem of physical and psycholog-

¹¹ World Health Organization Technical Report Series, 1951, No. 42.

¹² World Health Organization Technical Report Series, 1952, No. 48.

¹³ World Health Organization Technical Report Series, 1955, No. 94.

¹⁴ World Health Organization Technical Report Series, 1954, No. 84.

ical dependence and the occurrence of withdrawal symptoms. The committee described the "craving" for alcohol and the signs appearing after a sudden cessation or reduction of alcohol intake. It also pointed out the prognostic importance of alcoholic amnesias (so-called "black-outs"). The position of alcoholism in relation to drug addiction was examined, and the opinion was expressed that alcohol must be placed "in a category of its own, intermediate between addiction-producing and habit-forming drugs." The disorders induced by alcohol were finally classified with special consideration of the public health action called for by each of the categories distinguished.

(5) *Expert Committee on the Mentally Subnormal Child* (February 16-21, 1953)¹⁵

This expert committee was organized by the World Health Organization with the participation of the United Nations, ILO, and UNESCO. Its purpose was to give consideration "to the special problems presented by persons suffering from milder forms of mental subnormality or social incompetence." It was pointed out that children of this type often lack the assistance that would enable them to make full use of their limited abilities and potentialities. "In school they are very often educationally more backward than they need be, and in both adolescence and adulthood many of them present serious problems that would not have arisen had they been properly cared for in childhood."

It was proposed to divide mental subnormality into mental retardation and mental defect and to differentiate in both categories between mild, moderate, and

severe forms. The term "mental retardation" was proposed for "those whose educational and social performance is markedly lower than would be expected of what is known of their intellectual abilities," while the term "mental defect" was reserved for those whose "mental capacities themselves are diminished as a result of pathological causes." It was indicated that much research was required in order to determine the prevalence, the etiology, and the methods of assistance with regard to the different types. With respect to prevention, attention was called to the relation between emotional deprivation and mental subnormality. The committee reviewed in detail the services necessary for the treatment and education of mentally subnormal persons in infancy and early childhood, during school age, and in adolescence and early adulthood. It pointed out the need for special educational facilities and appropriate vocational guidance and vocational training. Reference was made to the training of personnel for the treatment and education of subnormal children. It was pointed out that a proper handling of these problems is only possible if the intelligent cooperation of the parents and the general public is assured. The need for special legislation was stressed, and in this connection it was stated that the main function of legislation relating to the subnormal must be protective, that over-protection should be avoided, that the required legislation should, as far as possible, be made within the framework of the general legislation referring to the rights and needs of children, and that machinery should be set up to provide for special contingencies such as guardianship, institutional care, procedures of certification or commitment, etc. The committee finally recommended that in the development of programs for the assistance of mentally subnormal children, care should

¹⁵ *World Health Organization Technical Report Series*, 1954, No. 75.

be taken to secure appropriate coordination of services, not only in the planning and execution of programs, but also in relation to the individual cases.

STUDY GROUPS

It has already been mentioned that in order to discuss problems of a very specialized nature, so-called "study groups" can be convened. Some of these were organized by the mental health unit alone, while others were arranged in cooperation with other units. A short resumé of the work done by these study groups is given below.

- (1) *Study Group on the Psychobiological Development of the Child* (January 26-30, 1953; January 7-13, 1954; February 17-23, 1955; September 20-26, 1956)¹⁶

In its first session the Expert Committee on Mental Health recommended that WHO should foster "research into the biological, psychological, and cultural determinants of personality structure," and also "actively sponsor psychological studies of the normal pattern of emotional and intellectual development in infants and children . . . since for mental health work a knowledge of the normal pattern of emotional and intellectual development is as important as is a knowledge of normal physical development to a pediatrician." Accordingly, a group was convened consisting of psychologists, psychiatrists, psychoanalysts, electrophysiologists, biologists, educationalists, cultural anthropologists, and animal psychologists, who examined child development with a view to synthesizing their different viewpoints.

In the first meeting, the knowledge (or lack of it) of the growth and maturation of the human nervous system, and the electroencephalographic changes during childhood were described; Piaget's and Wallon's systems for describing the stages of cogni-

tive and of motor development were outlined; current psychoanalytic theory as to the stages through which the child passes was briefly reviewed; the effects of different cultures on the rate and manner of emotional and intellectual development were described; and the elements of the comparative studies of animal behavior were outlined, with emphasis on the innate releaser mechanism and imprinting.

Presentations were made from each of the standpoints of different specialists and were discussed by the whole group, partly with the object of revealing the most important gaps in knowledge where further research would be important, and partly with the object of stimulating inter-disciplinary interest and coordination. It was stated that the physical or physiological growth process could be visualized as a series of waves of activity, affecting different parts of the body at different times; that one should not consider sharply-defined critical points in that growth period, but that probably there were periods of greater or less susceptibility to outside influences. It was shown that the relation between physiological and psychological developments required further study, as did the differential development as between the sexes. A description was given of the pattern of integration of the motor function by the central nervous system studied through the behavior of anencephalics. Stages of mental development were examined and illustrated by descriptions of

¹⁶ No reports on the sessions of this study group have been published by the World Health Organization. However, a condensed (English) version of the verbatim record of the first three meetings has appeared in London (Tavistock Publications, Ltd.) and New York (Basic Books, Inc.). A fourth volume containing the record of the last meeting is in print, and the publication of French and Russian versions is contemplated.

tests for the existence of "mental structures" as compared with tests of isolated pieces of behavior. It was pointed out that the study of structured wholes was insufficient if not completed by research in differential psychology. Behavior was discussed with particular reference to "instinctive" behavior or innate response to key stimuli, as compared with behavior resulting from conditioning and from learned responses. EEG records were related to certain aspects of children's personalities, particularly ductility, versatility, and stability, and an attempt was made to relate developmental changes in characteristic EEG activity to the stages of mental development previously described. Instinct theory was reviewed with particular reference to the concept of psychiatric illness as resulting from a disorganization of instinctual life, and of regression to the stages of instinctive response in infancy as affecting the behavior patterns in adult life. Finally, it was shown that what are considered as normal stages of development in one culture are not necessarily so in another.

In the second meeting, electromechanical models simulating aspects of animal learning and of the possession of "purpose" were demonstrated and discussed; experiments on what happens to humans when they are cut off from the majority of stimuli were described; some ways were demonstrated in which emotional crises can be produced in animals, both in adults and young animals; evidence was presented on how learning in children through identification and superego development occurs in different cultures. A presentation by a neurophysiologist postulated six main modes by which psychobiological development could occur, some of which were illustrated by thermionic models designed to show human behavior reduced to simple terms. Development through "reflexive" action was

demonstrated by a model showing purposive behavior which was shown to be not dependent on an elaborate nervous system. Another model, designed to show adaptation by imprinting, by instinct, and by association, appeared to have the property of allowing for a very specific response to be built up and later allowing for a variety of response, without any anatomical transformation (as in growing children).

It was pointed out that for the demonstration of development through learning by association or by conditioned reflexes a far more elaborate model was required. A description was given of toposcopic methods of observing how the human brain deals with information received, and was illustrated by case material. Factors in the normal development of behavior as studied by human and animal experiments in a psychological laboratory were then described. One series of experiments concerned the role of early learning or early experience in emotional and problem-solving behavior. Sensory or perceptual deprivation in the human adult was shown experimentally to result in loss of concentration and sometimes in hallucination. Other lines of research described concerned individual differences in reaction to stress and the reinforcement theory of learning. Since studies of chronic emotional disorders brought on by the stresses of conditioning in animals have contributed to an understanding of the functional significance of human emotions, a number of experiments carried out for this purpose were described, including some on the differences in reactions to stressful training between young animals left with and without their mothers during the experiments. Details were given of a comparative study of certain aspects of psychological development in different cultures. There was further discussion on behavior patterns in infants, on the possi-

bilities of measuring the learning process in man and its disorders by electrophysiological methods, and on the psychological process of registering facts and "storing" experience.

In the third meeting, the number of subjects discussed diminished although the range of the discussion was as wide as ever. The ways were described in which different cultures bring their children to assume a social role appropriate to their sex and the relation of this to adult sex differences in behavior and sex differences in emotional attitudes of American twelve-year-olds, as revealed in the models they made when asked to construct an exciting but imaginary scene with toys, were presented. The stages in the psychosocial development of the child were presented and discussed, with particular emphasis on how the values of his culture are transmitted to the growing child. Observations made in intensive clinical work, in a longitudinal study and in anthropological studies were used as a basis for the discussion of the development of ego-identity. Much discussion during this meeting was devoted to an attempt to translate the stages described in the development of personality by psychologists and psychoanalysts into neurophysiological terms, with reference also to cybernetic parallels.

In the fourth meeting, a somewhat different procedure was followed. This time one member of the group produced a paper for circulation, and the other members wrote comments on it. These comments were, in turn, precirculated. A discussion then took place, and afterwards, a final statement was circulated by the writer of the original paper. The main concern of this meeting was to find a level at which synthesis of the viewpoints and content of the various disciplines represented by the group could be made. This was perhaps the most interesting, but certainly the most

difficult, task undertaken. The concerted attempt at a synthesis led to a search for a language in which more than one branch of knowledge may be described, the language of information theory, general systems theory, and probabilistic logic. As a result, it became evident that in many cases different terminology had been used for the same ideas by the various workers, and that there was much greater agreement on the general problems of development than had originally been supposed. As a counterpoint, there was renewed discussion on the stages in a child's development, and a clearer understanding was reached with respect to interaction of the different factors—biological, psychological, and cultural—involved in it, of the way characteristic stages follow one another, and of the mechanisms at play.

(2) *Study Group on Juvenile Epilepsy*
(October 6–12, 1955)¹⁷

This meeting was convened "with the aim of obtaining as comprehensive a picture as possible of the problem of epilepsy and how to handle it, and to show this picture as widely as possible in various countries with the object of setting in motion the development of services." The group considered the prevalence, pathophysiology, and etiology of juvenile epilepsy. It referred to the role of the centrencephalic and temporal lobe systems in the pathophysiology of epileptic fits and commented upon the EEG patterns and their relationships to different forms of attacks. With respect to etiology, reference was made to hereditary factors, and the acquired factors were analyzed in detail. Much attention was paid to the psychological phenomena associated with juvenile epilepsy, such as secondary disturb-

¹⁷ *World Health Organization Technical Report Series*, 1957, No. 130.

ances of intelligence and behavior, primary and secondary neurotic complications, etc. Recommendations were made on the organization of medical and social guidance for the epileptic child and the problems of case-finding, pharmacological, surgical and psychological treatment, social handling, and educational and vocational practices were discussed. Finally, reference was made to the public health aspects of juvenile epilepsy, and measures for primary and secondary prevention were mentioned.

(3) *Study Group on the Treatment and Care of Drug Addicts* (November 19-24, 1956)¹⁸

The task of this study group, which was organized jointly by the mental health section and the section on addiction-producing drugs, was to examine the scientific knowledge and clinical experience on the treatment and care of drug addicts with a view to determining the principles which might be applied to the management of addicts with different etiology and coming from different cultural surroundings. The study group accepted the public health concept that "an addict is a person who habitually and compulsively uses any narcotic drug so as to endanger his own or others' health, safety, or welfare." Of the different drugs used and abused, only the opium alkaloids, the substances with morphine-like characteristics, and the cannabis substances were considered. The study group agreed that it is "not possible to describe the addict as a well-defined type," and with respect to the classification of addicts it decided to base it on the amenability of addicts to treatment. It differentiated between a group of

persons "who are exposed to some more or less accidental circumstances, such as exhaustion, hunger and poverty," a group of persons who become addicted as "the result of some episode of an illness physical or psychological in origin," and a group of addicts "composed of those who suffer from a basically pathological character structure." With respect to the treatment to be carried out, consideration was given to the (legal and administrative) circumstances of treatment and to the general principles of treatment. With regard to the latter, the group said that "it cannot be too strongly emphasized that the first principle of the treatment of drug addicts is that they should be looked upon as patients, that is to say, treated medically and not punitively."

It was also pointed out that "treatment must be based upon a study of the individual personality" and should therefore be of a fundamentally psychotherapeutic nature. The study group divided the treatment period into a preparatory phase, a withdrawal phase, and a phase of continued treatment, "all of which should be part of a continuing process which may have to extend over several years." The methods of gradual and abrupt withdrawal were described. With reference to the withdrawal of opiates or morphine-like substances, the Methadone substitution technique was recommended as being most effective, simple, and easy to carry out. The group noted a number of subjects for further study and in an annex furnished some background information on the etiology of addiction, the circumstances of treatment, and the treatment programs in use at present.

(4) *Study Group on Schizophrenia* (September 9-14, 1957)¹⁹

Immediately after the Second International Congress on Psychiatry (Zurich, September 1-7, 1957), the central subject of which

¹⁸ World Health Organization Technical Report Series, 1957, No. 131.

¹⁹ No report of this study group was published by the World Health Organization. A report was printed, however, in the *American Journal of Psychiatry*, 115(1959), 865-72.

was schizophrenia, 12 distinguished investigators were invited to review the problems of that disease, which, in many countries, accounts for more than half the number of hospitalized psychiatric patients. The group pointed out that "the diagnosis of schizophrenia has to be made on clinical evidence" and that "it cannot . . . depend on the course of the illness." The prominent clinical criteria of the illness were listed as: (a) an unmistakable change of personality; (b) social withdrawal with preference for private modes of thought and behavior (autism); (c) a disturbance of thinking; (d) emotional disturbances; (e) disturbances of perception; and (f) anomalies of behavior.

With respect to the etiology of schizophrenia, the group expressed the view that "the opinion which at present prevails . . . is that this disorder is in all cases of multifactorial origin, although the relative importance of different factors may vary from patient to patient." With regard to treatment, the group stated that "nearly every schizophrenic will respond favorably to at least some degree" and that the three types of treatment available, "somatic, psychological, and environmental, are complementary." The group pointed out that "no specific preventive measures are available," but that "all factors which permit good mental health may be assumed to be of use in preventing some of the manifestations." It also stressed that by appropriate measures a worsening of the condition or a chronic course can often be prevented ("secondary prevention"). The group finally made recommendations with respect to training, research, and public education.

(5) *Study Group on the Mental Health Aspects of the Peaceful Uses of Atomic Energy* (October 21-26, 1957)²⁰

In its activities concerning the risks to health involved in the exploitation of nuclear

energy, the World Health Organization considered in the first place the physical aspects. Since, however, "the opening of the Atomic Age may also be accompanied by pathogenic influences in the sphere of mental health," a study group was convened in order to examine and analyze these influences. The group started by reviewing the question of possible brain damage from radiation and came to the conclusion that "with the low dosages of radiation to be encountered in the peaceful uses of atomic energy, the organic brain effects . . . are of minor or no importance." It then tried to determine "the degree to which the development of atomic energy may affect mental health through the action of social and economic factors" and expressed the view that "the peaceful use of atomic energy has enormous potential for both helpful and harmful effects," and that "the question as to which effects will predominate hinges on the attention given to human factors in planning and in development." The group then sifted the evidence on unhealthy emotional responses immediately provoked by the advent of atomic energy, referring in this connection to the general public, the press, the authorities, the personnel of atomic establishments, and the radiologists and atomic scientists. It then analyzed this evidence, pointed out the anxiety-producing circumstances and qualities of atomic energy and their relationship to certain childhood experiences, and commented on the psychological interaction between scientists, authorities, and the general public. Finally, the study group outlined the mental health tasks which result from the problems encountered, suggesting remedial, educational and research measures with respect to brain damage, socio-economic risks, and specific

²⁰ *World Health Organization Technical Report Series*, 1958, No. 151.

emotional reactions. It also recommended the formation of interdisciplinary teams whose task it would be to contribute to the education of the community on different organizational levels.

(6) *Study Group on Ataractic and Hallucinogenic Drugs in Psychiatry* (November 4-9, 1957)²¹

The growth of interest in the action of ataractic and hallucinogenic drugs on mental function in man motivated the convening of this study group, which tried to limit its discussion to subjects not previously covered in other conferences and symposia and to emphasize those aspects in which the facilities of the World Health Organization could play their part. The study group started by examining the origins of present ignorance with respect to tranquilizers and hallucinogenic (psychosomimetic) agents and referred in this connection to the subjective nature of drug effects in man, the uneven progress of the behavioral sciences, and the equally noticeable lag in the development of the basic neurological sciences. It tried to establish psychophysiological correlates and to interpret them in the light of a theory of the psychoses; the hypothalamus, the reticular system, and the limbic system were particularly referred to, and the influence of drugs upon the metabolic background of the psychoses was examined. The problems of classification of drugs were studied, and a provisional classification was proposed. Six major groups were distinguished: (a) the major tranquilizers or neuroleptics; (b) the minor tranquilizers; (c) the hypnosedatives and tranquilosedatives; (d) the anti-acetylcholine drugs with

marked psychotropic effects; (e) the stimulant (psychoanaleptic or psychotonic) drugs; and (f) the hallucinogenic or psychosomimetic drugs. An effort was made to relate the drug-induced mental changes to psychoanalytic theory, and the implications of those considerations for psychotherapy were discussed. Although it was not within the terms of reference of the study group to weigh the relative merits of the various drugs in the management and treatment of the psychoses, some remarks were made on the effect of modern drug treatment on the hospital milieu and the future functioning of the mental hospital. Consideration was given to differences in the effects of and the needs for "psychotropic" drugs in different cultures. Finally, there was some discussion on specific research problems, and the uses and abuses of the new drugs were viewed from the public health point of view with regard to hospitalized and not hospitalized patients.

(7) *Study Group on the Mental Health Problems of Automation* (November 10-15, 1958)²²

The mental health impact of socio-economic changes, which had already been touched upon by the Study Group on the Mental Health Aspects of the Peaceful Uses of Atomic Energy, was studied in a detailed and specific way by the Study Group on the Mental Health Problems of Automation. The group started by pointing out the similitudes and the differences between the traditional type of industrialization and automation and then went into a detailed consideration of the mental health effects of the latter, particularly of "control automation" and "computer automation." It reviewed the consequences of individual strain through work in automated plants, first from the point of view of the hopes and fears that automation is inspiring in

²¹ *World Health Organization Technical Report Series*, 1958, No. 152.

²² *World Health Organization Technical Report Series*, 1959, No. 183.

many people, and then with regard to the physiological and psychological repercussions of work in automated undertakings. With respect to the latter, special attention was given to the effects of a reduction of manual work, an increase in perceptual activity, a more abstract nature of the individual's relations with the machine, and an increased responsibility of the machine operator. With regard to the mental health problems connected with social change caused by the introduction of automation, the group considered the influences which may be derived from changes in the location of industries, a possible increase of shift work, a greater amount of leisure time, and changes in occupational structure and mobility, with special reference to the situation of middle-aged and older workers. The mental health tasks ensuing from the introduction of automation were analyzed with respect to the work place, the working individual, and the social environment. In this connection the group emphasized that automation should not be considered one-sidedly as a source of new types of strain but also as a source of possible improvements in mental health. Finally, the need for further research was underlined, and a list of urgent research topics was given.

OTHER EXPERT MEETINGS

Apart from the meetings of expert committees and study groups summarized above, the mental health unit of the World Health Organization collaborated in a number of expert meetings which were jointly organized with other agencies of the United Nations family and certain intergovernmental and non-governmental organizations.

Thus, the World Health Organization and UNESCO convened an "Expert Meeting on Mental Hygiene in the Nursery

School,"²³ which was held in Paris from September 17-22, 1951. The proceedings of this meeting were used as one of the preparatory reports for the UNESCO European Conference on Education and the Mental Health of Children, which met in Paris from November 27 to December 7, 1952. After having reviewed the development of the nursery school and its function in the community, the experts examined the role of the mother and of the nursery-school teacher in the light of the child's needs and made recommendations with respect to the recruitment and training of nursery-school teachers. Special attention was given to the functions of the headmistress in nursery schools and to the problems of supervision by school inspectors. The meeting also referred to the shaping of public opinion and said that "the nursery can probably make a more far-reaching impression upon public opinion than can any mass public information campaign."

The United Nations and the World Health Organization convened a "Meeting of Experts on the Mental Health Aspects of Adoption"²⁴ which met in New York from September 13-20, 1952. The meeting concerned itself with adoption procedures and the principles upon which they are based, with particular reference to the way in which they have developed within the structure of western society. It called attention to the "principles of mental health which are fundamental to good adoption practices" and stated that they "relate basically to the safeguarding of normal growth and development in the child and in particular to the adequate growth of a capacity for harmonious relationships." In this connection, the group

²³ UNESCO, *Problems in Education Series*, No. 9.

²⁴ World Health Organization *Technical Report Series*, 1953, No. 70.

expressed the opinion that "the capacity of the mother and father for parental feeling towards the child" is of particular significance for the growing person's development of positive social responses. The meeting analyzed the needs of the adopted child, made recommendations about adoption procedures, considered the problems of the natural mother and of the adopting parents, and commented upon the selection and the training of the persons engaged in assisting with adoption procedures. Summing up, the meeting pointed out that "it is no amateur matter to decide which parents and home will fit each child" and that, therefore, "no child should be placed haphazardly with any adopting parents."

The Commission for Technical Co-operation in Africa South of the Sahara, the World Federation for Mental Health, and the World Health Organization convened a "Meeting of Specialists on Mental Health" in Bukavu, Belgian Congo, from March 10-18, 1958. This "fact-finding" meeting was preparatory to the mental health seminar which was organized subsequently in Brazzaville, French Equatorial Africa (see next section). It concentrated first on making an inventory of the present position of mental health work in Africa, examining the historical background, and surveying the prevalence of mental ill-health, the existing treatment and prevention facilities, the staff situation, and the training facilities in the various African countries and territories. Then it discussed specific problems, such as the similarities and differences in basic psychology with regard to social and cultural patterns in the various areas and the effects of accelerated social and cultural change on the mental health of

African populations. It finally examined the question of which problems call for research and what should be done with respect to future activities in the field of mental health.²⁵

The Milbank Memorial Fund, the World Federation for Mental Health, the British Medical Research Council, and the World Health Organization convened a "Joint Technical Meeting on Epidemiological Methods in Mental Health," which was held in London from September 15-22, 1958. Approximately 20 specialists in psychiatry, public health, and epidemiology discussed a document on epidemiological method in psychiatry, which in 1957 and 1958 had been prepared by a WHO consultant, Dr. Donald Reid of London, with the collaboration of other WHO consultants and staff members, and heard reports on current research work in the field of the epidemiology of mental disorder. No report of this meeting was published, but the results of its discussions were incorporated into Dr. Reid's document, which was used as a working paper for the eighth session of the Expert Committee on Mental Health and has since been published²⁶ in the WHO series *Public Health Papers*.

MEETINGS ORGANIZED BY OR ON BEHALF OF WHO REGIONAL OFFICES

As was pointed out in the general introduction to this article, the regional offices are normally responsible for the organization of field activities. This includes the organization of seminars, the main purpose of which is to contribute to the training of mental health workers. The Regional Office for Europe, which was the first to appoint a regional adviser in mental health, plans and executes these seminars independently, while in the other regions, the technical responsibility for these meetings

²⁵ A report was prepared but has not yet appeared.

²⁶ World Health Organization, *Public Health Papers*, No. 2.

has so far been entrusted to the mental health unit at headquarters. The Regional Office for Europe has furthermore convened a number of symposia of an advisory nature whose task it was to collaborate with the regional staff in the clarification of problems of specific interest to the European region.

(1) SEMINARS

Regional Office for Africa

A seminar was convened in November-December, 1958, in Brazzaville, French Equatorial Africa. Its subject was "the education and training of mental health personnel in Africa south of the Sahara." The seminar was co-sponsored by the Committee for Technical Cooperation in Africa South of the Sahara. A report containing the proceedings and recommendations, as well as the working papers written in connection with this seminar, was produced but was not generally distributed.

Regional Office for the Americas

A seminar on alcoholism was organized in May, 1953, in Buenos Aires, Argentina. It was attended by specialists from Argentina, Chile, Paraguay, and Uruguay. No report was published.

A seminar on mental health was convened in Montevideo, Uruguay, in July, 1955. It was attended by specialists from Argentina, Brazil, Chile, Ecuador, Paraguay, Peru, Uruguay, and Venezuela and covered a wide range of topics, with particular emphasis on the prevention and treatment of mental disorders, the mental health problems of children, the training of mental health workers, and the mental health education of the public. No report was published, but a short resumé of the proceedings of the seminar was given in the

*Chronicle of the World Health Organization.*²⁷

Regional Office for the Eastern Mediterranean

A seminar on mental health was convened in November-December, 1953, in Beirut, Lebanon. The participants came from a wide range of Eastern Mediterranean countries. A report was produced but was not generally distributed.

Regional Office for the Western Pacific

A seminar on mental health in childhood was convened in August, 1953, in Sydney, Australia. Specialists from both Western Pacific and Southeast Asian countries attended. A report of the proceedings was produced but has not been generally distributed.

A seminar on mental health and family life was convened in Baguio, Philippines, in December, 1958. It was co-sponsored by the Philippine government, the World Federation for Mental Health, and the Asia Foundation. A report of this meeting has been prepared, but has not yet been published.

*Regional Office for Europe*²⁸

A seminar and lecture course on alcoholism was convened in October-November,

²⁷ WHO Chronicle, 9(1955), 342.

²⁸ See also:

Buckle, D. F., "WHO Mental Health Program in Europe," *Journal of the American Medical Women's Association*, 13(1958), 454.

Buckle, D. F., "Das Mental-Health Programm der Weltgesundheitsorganisation in Europa, Praxis der Kinderpsychologie und Kinderpsychiatrie, 5(1956), 178.

Buckle, D. F., "Das Mental-Health Programm der Weltgesundheitsorganisation in Europa, Zeitschrift für psycho-somatische Medizin, 3(1956-57), 59.

1951, in Copenhagen. A report of this meeting was produced but has not been generally distributed.

A seminar on child psychiatry and child guidance work was convened in Lillehammer, Norway, in April-May, 1952. A report of this meeting was produced but was not generally distributed.

A seminar on the mental health aspects of public health practice was convened in Amsterdam, Netherlands, in July, 1953. A report was produced but was not generally distributed.

A seminar on the prevention and treatment of alcoholism was convened in Noordwijk, Netherlands, in March-April, 1954. A volume containing selected lectures presented at this seminar was produced but not generally distributed.²⁹

A seminar on mental health through public health practice was convened in Monte Carlo, Monaco, in April, 1955. No report of this meeting was published, but a summary account of it appeared in the *Chronicle of the World Health Organization*.³⁰

²⁹ World Health Organization, "European Seminar on the Prevention and Treatment of Alcoholism," selected lectures reprinted from the *Quarterly Journal of Studies on Alcohol*, 15(1954), and 16 (1955).

³⁰ *WHO Chronicle*, 9(1955), 247.

³¹ Buckle, D. and S. Lebovici, "Child Guidance Centers," *World Health Organization: Monograph Series*, 1958, No. 30.

³² Furthermore, a seminar on the medico-psychological and social examination of offenders was held in Brussels, Belgium, in December, 1951. This meeting was organized by the Technical Assistance Administration and the Department of Social Affairs of the United Nations Secretariat, with the cooperation of the World Health Organization. See *International Review of Criminal Policy*, (New York: United Nations, 1953).

³³ *Bulletin of the World Health Organization*, 12 (1955), 427.

A seminar on child guidance was convened in Lausanne, Switzerland, in September, 1956. No report was published, but the material presented during this seminar was used in the production of a monograph.³¹

A seminar on the mental health of the subnormal child was convened in Oslo, Norway, in April-May, 1957. A report was produced but was not generally distributed.

A seminar on the nurse in the psychiatric team was convened in Noordwijk, Netherlands, in November, 1957. A report of this meeting was produced but not generally distributed.

A seminar on the psychiatric treatment of criminals and delinquents was convened in Copenhagen, Denmark, in April-May, 1958. A report was prepared but was not generally distributed.

A seminar on the mental health of the subnormal child was convened in Milan, Italy, in May, 1959. A report is in preparation.

A seminar on mental hygiene practice was convened in Helsinki, Finland, in June-July, 1959. A report is in preparation.³²

(2) Meetings of Symposia of the European Regional Office

A symposium (advisory group) on the care of children in hospitals was convened in Stockholm, Sweden, in September, 1954. A report on this meeting was published in the *Bulletin of the World Health Organization*.³³

A symposium on mental health problems of displaced persons was convened in Geneva, Switzerland, in August, 1955. The task of this group was to study a report on a 1954 pilot study on the mental health of children living in refugee camps in Austria.

A symposium on human relations and mental health in industrial units was convened jointly with the International Labor

Office in December, 1956, in Geneva. A report was produced but not generally distributed.

A symposium on preventive mental health work with children was held in Copenhagen, Denmark, in September–October, 1958. A provisional report was produced but was not generally distributed.³⁴

PUBLICATIONS SPONSORED BY THE MENTAL HEALTH UNIT AT HEADQUARTERS

Partly in connection with meetings organized at headquarters, and partly with the purpose of advancing specialized knowledge in the mental health field, the mental health unit at headquarters has carried out or sponsored a number of studies that have appeared in the *Monograph Series* of the World Health Organization, the WHO series *Public Health Papers*, the *Bulletin of the World Health Organization*, and the *International Digest of Health Legislation*. Other studies have been published independently. A list of these publications is given below:

Monograph Series:

Bovet, L., "Psychiatric Aspects of Juvenile Delinquency," *World Health Organization: Monograph Series*, (1951), No. 1.

Bowlby, J., "Maternal Care and Mental Health," *World Health Organization: Monograph Series*, (1952), No. 2.

Carothers, J. C., "The African Mind in Health and Disease: A Study in Ethnopsychiatry," *World Health Organization: Monograph Series*, (1953), No. 17.³⁵

Public Health Papers:

Baker, A. R., Llewelyn Davis, and P. Sivadon, "Psychiatric Services and Architecture,"

World Health Organization: Public Health Papers, No. 13.

Reid, D. D., "Epidemiological Methods in the Study of Mental Disorder," *World Health Organization: Public Health Papers*, No. 2.

Bulletins of the World Health Organization:

Guttmacher, M. S., "Medical Aspects of the Causes and Prevention of Crime and the Treatment of Offenders," *Bulletin World Health Organization*, 2(1949), 279.

Guttmacher, M. S., "Psychiatric Examination of Offenders," *Bulletin World Health Organization*, 2(1950), 743.

Macfarlane, J. W., "The Uses and Predictive Limitations of Intelligence Tests in Infants and Young Children," *Bulletin World Health Organization*, 9(1953), 409.

Tizard, J., "The Prevalence of Mental Subnormality," *Bulletin World Health Organization*, 9(1953), 423.

Geber, M. and R. F. A. Dean, "Psychological Factors in the Etiology of Kwashiorkor," *Bulletin World Health Organization*, 12(1955), 471.

Krapf, E. E., "On the Pathogenesis of Epileptic and Hysterical Seizures," *Bulletin World Health Organization*, 16(1957), 749.

Geber, M. and R. F. A. Dean, "Psychomotor Development in African Children: The Effects of Social Class and the Need for Improved Tests," *Bulletin World Health Organization*, 18(1958), 471.

Tooth, G., "The Psychiatric Hospital and Its Place in a Mental Health Service,"

³⁴ Most of the reports of regional meetings which were "produced but not generally distributed" can be obtained on application to the respective regional directors.

³⁵ A further monograph, Buckle, D and S. Lebovici, "Child Guidance Centers," *World Health Organization: Monograph Series*, (1958), No. 40 has been referred to ³¹.

Bulletin World Health Organization, 19 (1958), 363.⁸⁶

A special issue of the *Bulletin*, devoted exclusively to mental health problems, will be published in the near future. It will contain a series of papers prepared in connection with the fifth, sixth, seventh, and eighth expert committees (described earlier), and with the Study Group on Ataractic and Hallucinogenic Drugs in Psychiatry, also referred to earlier. A complete list of these papers is given below:

Bash, K. W., "Mental Health Problems of Aging and the Aged from the Viewpoint of Analytical Psychology."

Townsend, P., "Social Surveys of Old Age in Great Britain."

Sjögren, T., "Changing Age-structure and its Impact on Mental Illness, Especially Senile Psychosis."

Roth, M., "Mental Health Problems of Aging and the Aged."

Sandison, R. A., "The Role of Psychotropic Drugs in Group Therapy."

Sandison, R. A., "The Role of Psychotropic Drugs in Individual Therapy."

⁸⁶ The *Bulletin of the World Health Organization* also published three papers on psychiatric problems in industry which were produced in connection with the work of the Regional Office for Europe in the field of social and occupational health and which are listed below:

Koekkebakker, J., "Mental Health and Group Tensions," *Bulletin of the World Health Organization*, 13(1955), 543.

Ling, P. M., "La Santé Mentale dans l'Industrie," *Bulletin of the World Health Organization*, 13 (1955), 551.

Mindus, E., "Outlines of a Concept of Industrial Psychiatry," *Bulletin of the World Health Organization*, 13(1955), 561.

⁸⁷ Independently published articles also were sponsored by the Regional Office for Europe, for example: Gibbens, T. C. N., "Psychiatry and the Abnormal Offender," *Medico-Legal Journal*, (Cambridge, England), 24(1956), IV.

Jacobsen, E., "The Comparative Pharmacology of Some Psychotropic Drugs."

Kline, N., "Psychopharmaceuticals: Effects and Side-effects."

Lindemann, E., "Relation of Drug-induced Mental Changes to Psychoanalytic Theory."

Stengel, E., "Classification of Mental Disorders."

Sivadon, P., "Transformation d'un Service d'Aliénés de Type Classique en un Centre de Traitement Actif et de Réadaptation."

International Digest of Health Legislation:

World Health Organization, "Hospitalization of Mental Patients: A Survey of Existing Legislation," *International Digest of Health Legislation*, 6 (1955), 1.

Published Independently:

Apart from a number of articles that have appeared in scientific journals, mention should be made of the proceedings of the Study Group on the Psychobiological Development of the Child, which are referred to earlier.⁸⁷

CONSULTANTS AND ADVISERS

As has been mentioned in the general introduction to this article, the World Health Organization, at the request of member governments, provides short-term consultants and long-term advisers. Between 1948 and 1959, nearly 30 countries availed themselves of consultant services, in some cases on several occasions, and six countries were provided with long-term advisers who stayed from one to three years. In certain cases, different long-term advisers also worked simultaneously or successively in the same country.

Further assistance to member governments was given by providing lecturers on

mental health and allied subjects and by visits from members of the mental health staff of WHO Headquarters and regional offices.

FELLOWSHIPS

By October 31, 1959, the organization had granted 479 fellowships for the purposes of study and exchange of knowledge on mental health subjects to citizens of over 30 member States.

COLLABORATION WITH OTHER UNITED NATIONS AGENCIES AND NON-GOVERNMENTAL ORGANIZATIONS

The World Health Organization has collaborated on numerous occasions with other United Nations agencies. In some cases, headquarters and regional offices were represented by staff members at meetings organized by other agencies, and in other cases, representatives were specially appointed for such meetings. Staff members have presented a number of scientific papers at national and international congresses and conferences. Particularly close relationships were maintained with the (non-governmental) World Federation for Mental Health. Staff members have also participated in broadcasts and other activities devoted to the education of the general public in mental health matters. Special attention was paid to this latter activity in 1959 since, in that year, "Mental Illness and Mental Health in the World Today" was chosen as the theme of World Health Day. The issue of the WHO magazine, *World Health*, for May-June, 1959, was specifically devoted to mental health.

CONCLUDING REMARKS

It is to be hoped that the account of the work of the World Health Organization in

the field of mental health that has been given in this paper may not only reflect what has been done in the last 11 years but also convey something about the principles which have inspired that work. Some remarks about the difficulties that arise in connection with the international approach to the problems of mental health were made in a paper which was published in the mental health issue of the *UNESCO International Social Science Journal*.³³ Here it may suffice to mention only two points of critical importance.

The first is that the battle for mental health cannot be won by psychiatrists alone. It requires consistent teamwork in which nurses, social workers, psychologists, teachers, ministers of religion, administrators, judges, employers, trade union leaders, journalists and many others can make important contributions. It is perhaps one of the greatest benefits of the international approach to mental health matters that it can show the psychiatrist the limitations of his own field.

The second point that should be stressed is that it is of fundamental importance to recognize the cultural and social differences between different areas and to take them into account in any recommendation for change that is proposed. As has been said in the paper just mentioned: "We may perhaps admit that everywhere in the world mental health presupposes an ability to perceive reality as it presents itself in the world and in the intimacy of the human being in an undistorted way, and a capacity for balanced action which manages to give satisfaction to both the physical needs and the cultural aspirations of the individual. But

³³ Krapf, E. E., "The International Approach to the Problems of Mental Health," *International Social Science Journal*, 11(1959), 1, 13.

international experience constantly reminds us that clear and full perception and harmonious action which is 'actualizing' the self at its optimal level do not always lead to 'happiness and effectiveness' in the Western sense, nor will they always and everywhere imply 'the ability to hold a job, have a family, keep out of trouble with the law and enjoy the usual opportunities for

pleasure.' In fact, it teaches us even more: it makes us realize that even where ideals of the type just mentioned can be accepted as appropriate, mental health as a value can only be understood within the value system of which it is an integral part and should not be striven for without a clear awareness of its dynamic articulation with other values."

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Current aspects of psychiatry in Great Britain

Part 1

BACKGROUND

In the latter part of the last century, responsibility for the care of the mentally ill rested with the local authorities. Their interest was confined to those whose behavior was so disturbed that they were incapable of looking after themselves or became a danger or nuisance to others. With a few exceptions, treatment was purely custodial. It consisted of segregating the patients into huge, prison-like asylums, mostly situated well away from large centers of population. Here, there was little danger of their interfering with the normal business of society, and land was cheaper. Admission, needless to say, was often long-term or lifelong. These hospitals stand today—like obsolete battleships stranded on some remote sandbank—a formidable problem bequeathed by our Victorian predecessors. They were, however, providing

one of the earliest of the welfare services, and certification was partly a method of demonstrating the need for a patient to receive care (Ministry of Health Report, 1958). That the hospital regime was rigorous or even penal was not surprising, considering the appalling living conditions of much of the outside population.

Some mental patients, however, through lack of asylum accommodation, fell within the province of the Poor Law and were accommodated in the workhouse infirmaries.

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Part 1 of this series deals with the historical aspects of the subject. Part 2, which will appear in October, will concern most of the important and recent developments in the field.

These were buildings whose size and character resembled the asylums although they were situated mostly within the larger towns. Here, these patients formed part of an agglomeration which included also the physically infirm, mental defectives, and those who were merely destitute. Sorting out the residue of this population is a process which is scarcely accomplished yet, although the majority of these institutions have been general hospitals for 12 years.

In the early part of this century, there developed a separate network of institutions in which most mental defectives were accommodated, following a series of acts regulating their care. The extent of the problem had become manifest for the first time following the introduction of universal compulsory education in the 1870's (Hargreaves, 1958).

These buildings, however, were few, compared with the lunatic asylums and Poor Law institutions, and it was not until the National Health Service that the responsibility for mental defectives was clearly established—resting on local authorities and regional hospital boards.

Up to the 1930's, this was virtually the totality of psychiatric services, apart from a small number of out-patient departments which developed mostly in teaching hospitals after World War I. Following the Mental Treatment Act of 1930, asylums (which were renamed mental hospitals) were encouraged to open their own out-patient clinics, but these were mostly limited to securing early, treatable cases as voluntary patients for admission.

SOCIAL LEGISLATION

In the period 1944-48, the welfare state came into being as the result of a series of measures which were based on the Beveridge Report. The Education Act was fol-

lowed by a comprehensive National Assistance Act (which removed the last traces of the old Poor Law), by the Industrial Injuries Act, and by the National Health Service Act.

Under the National Health Service, all general and mental hospitals were absorbed into the state scheme and (with the exception of teaching hospitals) were placed under the direction of 14 regional hospital boards. The local health authorities continued to provide a number of public hygiene services, including health visitors, district nurses, ambulances, and accommodations for the elderly. They were given vaguely defined functions in the fields of preventive medicine and after-care but generally lacked the financial resources to carry these out effectively.

NATIONAL HEALTH SERVICE

In 1948, the National Health Service took over institutions which varied widely from one authority to another and inherited an acute shortage of trained psychiatrists and of other grades of qualified staff. Further, the mental hospitals were a service almost entirely divorced from the main stream of development in medicine—one regarded by the general public with fear and suspicion. The first major problem was, therefore, that of assimilating them into the general pattern of health services as a whole.

The situation had been worsened by the war, which caused a complete cessation, not only of all new hospital building, but even of routine maintenance. As a result of this, and of bomb damage, many hospital buildings were in a very bad state. There was little improvement in the post-war period of economic difficulties. Hospitals took a very low place in priority for capital development in comparison with defense, housing, power, schools, etc., and it is only

in the last few years that there has been real progress in this direction.

Moreover, the health service was being faced with a greatly increased demand for treatment in mental hospitals; admissions increased by 400 per cent in the period 1932-1957 (Cooper, 1958). Apart from the universal availability of free treatment under the National Health Service, many factors must have been concerned in this trend. The population was growing larger and becoming more urbanized; there had been widespread uprooting during the war, and its aftermath was a time of stress and privation; more out-patient clinics resulted in more patients being recommended for admission. The stigma of mental illness was decreasing at this time, and patients were coming forward more readily for treatment.

It may be appreciated, then, that the provision of full, modern psychiatric facilities for the whole country presented a truly Herculean task.

BREAKING DOWN OF BARRIERS

With the introduction of the National Health Service, the previous rigid segregation of mental hospital patients from the community began to lessen. A pioneer in this field was Warlingham Park Hospital, and in succeeding years, the same trend occurred throughout the country. Doors and gates have become unlocked; patients have gained greater freedom, both within the hospital and to go out for daily and week-end leave; strict separation of the sexes has been ended. The number of patients detained under certificate has fallen steadily, while those admitted voluntarily or informally have correspondingly increased. Many patients now go out to work from hospitals as a prelude either to discharge home or to entering a local authority hostel.

The ending of authoritarianism is a vital factor in the progress of psychiatric treatment. In the first place, it helps to prevent that institutionalization which produces the chronic mental patient and often rules out a return to the outside world (Barton, 1959). Secondly, it alters the relationship between hospital and community so that the hospital is no longer a place to be feared or despised.

MacMillan (1958) has pointed out that certification encourages the members of the community to regard the mental patient as a person apart from themselves, and that no true therapeutic relationship can develop when the patient is legally inferior to the doctor or nurse. The same point has been emphasized by Mandelbrote (1959): "For the mental hospital to play its role effectively, it is very important to provide an internal psychotherapeutic atmosphere within the hospital; this, in turn, will have the function of further enlightening an informed public opinion in the community."

The principle of the custodial institution has been replaced by that of the "therapeutic community"—one in dynamic equilibrium with the community outside.

However, it has recently been pointed out by the Ministry of Health that some patients will remain for whom the maintenance of adequate security precautions is an essential part of their hospital care. Public confidence in mental hospitals and their present open-door policy might be shaken if serious incidents occurred, involving patients whose mental state was such that they should have been detained. To avoid this, it is suggested that either each hospital should maintain special security precautions in part of its accommodation, or that regional units should be established for certain classes of patients.

ROYAL COMMISSION

In 1953, Sir Winston Churchill announced in Parliament that there was to be a Royal Commission to inquire into the law dealing with those suffering from mental illness and mental defect. The commission received evidence from over 100 British associations, societies, local authorities, hospital authorities, and government departments. Most of the witnesses were unanimous in their wish to have new legislation to replace the old Lunacy Act, Mental Treatment Act, and Mental Deficiency Acts, which incorporated out-dated assumptions and attitudes.

The report of the Royal Commission in 1957 had two broad themes. It sought, first, to abolish the administrative and legal distinctions between mental and other forms of illness, and, secondly, to shift the emphasis from treatment within the hospital to treatment within the community. It made recommendations for the law to be altered. Whenever possible, care should be provided for mentally ill patients with no more restriction of liberty or legal formality than for those needing other types of care or treatment. Compulsory powers were to be used only when positively necessary.

The report was well received on all sides and acclaimed as a great social document. It established a clear need for new legislation and provided a blueprint for the Mental Health Act of 1959.

A NEW ERA AND LEGAL CODE

One of the earliest reforms in the treatment of the mentally ill was the removal of their chains, and the latest, the Mental Health Act, releases psychiatric patients from some of their legal fetters. The Lunacy Act of 1890 used to be the principal law regulating the treatment and detention

of the mentally ill. The Mental Treatment Act of 1930 made it possible for people to obtain treatment in mental hospitals as voluntary patients without certification and contributed to a marked improvement in mental hospital practice over the past 25 years. The 1959 Act marks the beginning of a new era, will abolish the former certification procedure, and ensures that the majority of psychiatric patients will be admitted informally, with no more restriction than is applied to patients in general hospitals.

The new Mental Health Act provides for a single legal code to cover both mental illness and mental deficiency. Thus, the Lunacy Act, the Mental Treatment Act, and the Mental Deficiency Acts are abolished. The new act sweeps away the former designation of certain hospitals for mental illness or mental deficiency, so that any—including general hospitals—may in the future accept psychiatric patients. An increase is, therefore, expected in the treatment that will be available for psychiatric illness in general hospitals.

Some of the legal definitions in the old codes have been happily removed from official terminology. The term "mental disorder" will cover all forms of mental illness and disability. For the purpose of compulsory detention (to be used only as a last resort), the act recognizes four groups: the mentally ill, the severely sub-normal, the sub-normal, and the psychopathic. The term "severely sub-normal" deals with the more handicapped and the term "sub-normal," with some patients previously classified as "imbecile" or "feeble-minded." Psychopathic disorder is defined as "a persistent disorder or disability of mind (whether or not including sub-normality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient and requires

or is susceptible to medical treatment." Even the legal definition of a psychopath was a problem of the utmost complexity, and the inclusion of this category is a new feature to British mental health legislation. Most implications in relation to treatment have still to be worked out.

The new procedure for compulsory admission to a hospital is to be used only when every available alternative method has been considered. It dispenses with a judicial order (except in criminal court cases) and requires, instead, two medical recommendations, one of which has to be made by a specialist in psychiatry.

SAFEGUARDS

There are two important safeguards in the act against improper detention. One is the two medical recommendations, already referred to, which are needed in all cases except emergencies, when one will suffice for the first 72 hours. The second is that patients compulsorily detained can apply for their release to Mental Health Review Tribunals any time within six months of admission. These tribunals will be less remote and more accessible bodies than the Board of Control, whose good work at the Ministry of Health is to be brought to an end. One tribunal will be set up for each of the hospital regions and will consist of legal, medical, and lay members with experience in administration or knowledge of the social services. The tribunals will have wide powers to consider applications for the release of psychiatric patients compulsorily detained—either from the patients themselves or from their relatives—and will also have power to discharge them.

There are other changes with respect to

power of discharge. The general rule remains that the nearest relative of all patients admitted under the new procedure will hold this power, except for those detained under court orders. Powers of discharge are also given to the doctor responsible for the patient's treatment, to the hospital managers, and to local authorities in cases of guardianship or patients detained in private nursing homes.

EMPHASIS

The Royal Commission Report and a previous report of the WHO have drawn attention to the fact that admission to a mental hospital should be considered as an episode in the care of the patients, to be resorted to only when treatment can be given in no other way.

This aspect is being taken into account in the development of British mental health services and is illustrated by the enormous growth of psychiatric out-patient attendances and by the development of day hospitals and community care services. All these changes emphasize the trend away from in-patient treatment but also make it necessary to think of social conditions in the community outside. "We need the willingness to study the structure of our society itself, in which it becomes possible to break down in mental health, and see how far it is necessary to alter society rather than adapt the individual to fit society's demands" (Kahn, 1958).

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Summer camping in the treatment of ego-defective children

The problems involved in the social and psychological treatment of disturbed chil-

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¹ An interesting description of one of the first treatment camps is found in Rademacher, E. S., "Treatment of Problem Children by Means of a Long-Time Camp," *Mental Hygiene* 42(April, 1958), 385-94.

² The nature and extent of present-day therapeutic camping is discussed in McNeil, Elton E., "The Background of Therapeutic Camping," *Journal of Social Issues*, 13(1957), No. 1.

dren have led practitioners in the field of mental hygiene to search constantly for new treatment methods and facilities. Group therapy and social group work have been added to individual psychotherapy, and paralleling these developments has been the growth of year-round residential treatment of various types. A relatively recent development has been the use of the summer camp for therapeutic purposes.¹ Although still modest in its scope, the trend toward summer camping as an adjunct to therapy is likely to increase.² Several camps in various parts of the country have been set up specifically to serve disturbed children and others with special needs. Also, some agency camps are enrolling these children in small numbers with regular campers in an attempt to further their socialization.

An early attempt to describe the thera-

peutic rationale of summer camping was made in a perceptive article by Hallowitz.

"If the child's behavior and needs are understood, and he meets with tolerance, warmth, and encouragement from the counselor, he will soon realize that this adult is different from his own parents. Old patterns of adjustment will no longer be necessary. New ones will come to the fore. Healthy and mature responses can be encouraged, and infantile and unwholesome patterns discouraged. The counselor becomes like a parent, and the child has an opportunity to relive his early, formative years in which the parent's love or denial of love is so important in his training. The child now begins to make appropriate responses and can exercise control over his asocial impulses, not through fear of punishment, but in order to please and gain the love of the parent (counselor). While at first these new patterns are created just to please someone outside himself, later they are incorporated and become part of his own demands on himself."

This, of course, represents an idealized model of the therapeutic process that may occur in a camp setting and does not adequately reflect some of the technical problems involved in dealing with disturbed children. Subsequent experience in therapeutic camping has given us a clearer picture of these problems and has indicated that it is unrealistic to anticipate the achievement of such dramatic results with most disturbed children in the rather short period involved in summer camping.

THE DISTURBED CHILD'S PROBLEMS AS A CAMPER

The difficulties in work with disturbed children at camp are great. Even the relatively stable child is subjected to many unaccustomed strains in this setting. The isolation of the usual camp site and the presence of strange and unknown objects in the woods, as Redl points out, are likely to activate fantasies and stimulate fears.⁴ To these tensions are added those occasioned by the requirement that the child relate

closely and with a minimum of friction to a large number of peers.⁵

The disturbed child must face even more. He has to contend with the panic which separation and a new setting and people usually engender in him. He is called upon by the nature of the situation to carry out functions which demand a great deal of control; he must share an adult with many others, tolerate a number of unaccustomed routines, and weather the mistreatment which will inevitably occur at some point during interaction with any group of children. These are facts which cannot be overlooked in any discussion of the advisability of camping for disturbed children.

THE IMPORTANCE OF SELECTIVITY IN CAMP INTAKE

Consideration of the potentialities of camping for disturbed children must also involve some discrimination among levels of disturbance. Not all of these youngsters respond in a similar fashion to camping, nor do all have the same ability to make use of it. Hallowitz, even while emphasizing the value of camping for disturbed children, cautions us that some of them are not ready for this experience. "Some children," he writes, "need a more controlled and repressive environment; others suffer from too close an association with members of the same sex, and still others are too disturbing to their fellows, so that while they benefit from the experience, they min-

³ Hallowitz, Emanuel, "Camping for Disturbed Children," *Mental Hygiene*, 34(July, 1950), 409.

⁴ Redl, Fritz, "Psychopathologic Risks of Camp Life," *The Nervous Child*, 6(No. 2, 1947).

⁵ The highly charged atmosphere in which this must usually be accomplished is discussed in Schwartz, William, "Camping and the Group Experience," *Group Work Papers* (Chicago: Group Work Section, Chicago, Ill., Chapter, National Association of Social Workers, 1958).

imize or even destroy whatever benefits the other children might receive."⁶

As awareness of this point has increased, some treatment camps have become more selective in their intake.⁷ Faced with limitations on size of staff and on numbers of counselors with appropriate backgrounds and training, they have found it wise to take as campers only those disturbed children whose egos are not greatly damaged. As Staver and her colleagues have written: "The interaction of the camp group is robust, and even a proportion of about one adult to two children is not sufficient to allow long-time individual supervision of the more disturbed child. For these reasons, we feel that children who are too disturbed to achieve any real integration with the group or to get along without virtually full time individual supervision should not be accepted."⁸

NEED FOR EXPERIMENTATION WITH MORE SERIOUSLY DISTURBED

It would be unfortunate, however, if the cautions just cited were to lead to overly rigid intake policies for camps interested in helping disturbed children or to a refusal to undertake new ventures with the more deeply disturbed among them. It is important that agencies continue to investigate the potentialities of summer camping as a medium of service and treatment, not only for those disturbed children who have displayed some tolerance for group associa-

tion and whose egos are relatively intact, but also for ego-defective children whose capacity to relate in groups appears to be substantially below average.

A CAMPING EXPERIENCE FOR A GROUP OF EGO-DEFECTIVE GIRLS—FIRST SUMMER

In the summer of 1955 the Department of Neighborhood Clubs of the Boston Children's Service Association was presented with a special opportunity to study the reactions of several ego-defective children to camping. Among the clubs which had been conducted by the department during the previous winter and spring was one group composed of several teen-age girls who, at the time of their referral, had displayed a marked inability to relate to their age-peers or adults. The girls had been together for seven months prior to the summer. During that time they seemed to find satisfactions in some of the activities and the relationship with the leader and had been able to remain together as a group. Occasionally, they functioned surprisingly well as a unit. Their ways of relating were still quite primitive, however, and their behavior, by and large, continued to reflect severe impairment of ego-functioning. The department staff, while aware of the pitfalls, felt that it would be worthwhile to explore the reactions of this group to camping in order to determine whether under special circumstances—including a common group experience prior to camp and the group leader present as a camp staff member—it would not be possible for these ego-defective girls to remain at camp over an 11-day camping period and make constructive use of the experience without interfering with whatever benefits the other campers might receive.

The department's summer camping operation reflects the basic aims of our service

⁶ Hallowitz: *op. cit.*, pp. 419-420. See also Aldridge, Gordon J., and D. Stewart MacDonald, "An Experimental Camp for Emotionally Disturbed Boys," *Journal of Child Psychiatry*, 2(1942), Sec. 3, 251.

⁷ See Staver, Nancy, Manon McGinnis, and Robert Young, "Intake Policies and Procedures in a Therapeutic Camp," *American Journal of Orthopsychiatry*, 25(January, 1955), 148-61.

⁸ *Ibid.*, p. 154.

and the approaches to group composition we employ in our year-round work. The department provides a group work service for physically handicapped and/or emotionally disturbed children who are experiencing marked difficulties in their social relationships.⁹ Children are referred to the department by casework, educational, group work, medical, and psychiatric agencies. Usually they are referred individually by agencies and a group of relatively normal children is formed around each of them in his or her own neighborhood. Sometimes, however, several disturbed or handicapped children are referred together and accepted for service as a group.

At camp, as in the year-round program, we are interested in furthering the integration of disturbed or handicapped children with their "normal" peers wherever this appears to be feasible and clinically desirable. Each child attends camp with his own club, and the members of several clubs attend each camping session together. In this setting, even if his own club group is composed entirely of other handicapped or disturbed children, the handicapped or disturbed child is brought into close contact with a number of youngsters who are relatively normal and stable.

The camp itself is located 25 miles from Boston. At the time material for this paper was collected, it was conducted on a single sex basis, with about 25 children from four or five different clubs, all of the same sex, but of different ages, attending each camping session together. These camp sessions were brief, being only 11 days in duration. The physical area of the camp comprised 13 acres. The staff included three regular department workers as director and supervisors and eight other counselors, all of them students in social work or related fields.¹⁰

The group to be studied was composed

of five adolescent girls, two of whom were in the borderline or psychotic categories, and four of whom had severely damaged egos. This group had been formed on a trial basis after considerable discussion among school guidance personnel and the department's staff and psychiatric consultant.

The original member was Andrea, age 13, who had been referred by a casework agency where her mother was being seen. An only child, both of whose parents worked, Andrea had been raised by a very disturbed grandmother living in the home. When she was eight, her parents had placed her in a residential treatment center. Three years later, against the advice of the center's staff, they brought her home and enrolled her in public school where she was assigned to a special class. Here she was extremely aggressive and had to be put on a three hour a day schedule. At school, repeating the pattern she had displayed at the treatment center, she functioned as an isolate and made no friends in or out of class. Tests revealed an I.Q. of 82, although it was felt this was well below her potential. Andrea's emotional problems were complicated by a mild spastic condition.

The other members had been selected by the school guidance department from special classes. Each had at some time ex-

⁹ The nature of the department's practice is discussed in Kolodny, Ralph L., "Research Planning and Group Work Practice," *Mental Hygiene*, 42 (January, 1958), 121-132.

¹⁰ Since that time, the system has been changed to include both boys and girls at each session, and the acreage has been enlarged. The camping period has been extended to 18 days and the number of campers and staff has been increased. The department's camping practices are reviewed in Kolodny, Ralph L. and Virginia M. Burns, "Group Work with Disturbed and Handicapped Children in a Summer Camp," *Social Work with Groups* (New York: National Association of Social Workers, 1958).

pressed a desire to participate in some kind of group, but because of poor or inappropriate ways of relating to others, had experienced little association with other youngsters. These other members were: Genie, 12; Grace, 13; Dolores, 13; and Janine, 16.

Genie was a seriously retarded youngster who also suffered from a hearing loss. She had been in special class since first grade and was friendly only with five and six-year-olds. She was resentful of her intellectually normal older sister. Obese, withdrawn, and slow moving, Genie frequently appeared depressed and inert.

Grace was receiving casework help at the time the group was formed. Rejected by her mother, she was oppressed by marked feelings of inadequacy. She had *petit mal* epileptic seizures. Although quite normal in her speech and outward appearance, Grace was unable to read. Physically she was quite attractive and, as the club began to function, she exhibited more maturity in social relationships than did the other members.

Dolores was the most obviously "different" of all the members. Her speech and gait were infantile and in her conversation, which was often irrational, she exhibited a preoccupation with fears of death, blood, direct and physical pain. She had been seen once a week at a child guidance clinic for three months but had been taken out of treatment by her mother.

Janine had been afflicted with polio-encephalitis at the age of nine. Her speech and toilet habits were severely affected as a result, and she was left with a paralysis of the right arm. After several years of special

schooling, she re-entered public school. Placed in a special class on the basis of an I.Q. of 75 she began to show signs of extreme confusion. Her disturbance became acute, and she was committed to a mental hospital where she was diagnosed as schizophrenic. She returned to public school after discharge several months later and was now receiving casework on an out-patient basis. At her own request Janine was living with her grandmother, being unable to tolerate her brothers and sisters.

The results of our study of the behavior of these girls during the summer of 1955 have been reported in detail in an earlier publication.¹¹ Their first summer at camp was a stormy one for them. The stresses of the experience produced severe reactions, particularly during the first several days. A kind of group fragmentation occurred as each member became preoccupied with her own survival and paid little attention to others. Andrea sought out counselors rather than campers, but related to both primarily through bursts of hostility. She was obviously angry with her club leader, who was camp director, for not giving her enough attention. A counselor had to be with Janine constantly during the first two nights as she was very apprehensive and hallucinated, hearing bombs and sirens. Grace stayed in the kitchen most of the time, repeating the role she played in her own family and ate and worked with the kitchen staff. It was not until the third day that she felt secure enough to give up the protection of this isolated position. Dolores frequently stuffed dirt and stones in her mouth in the manner of an infant. Genie refused to eat the first meal and initially spent most of her time sitting and watching in hostile silence.

The intensity of their initial reactions diminished, however, as time went on and there was observable movement on the part

¹¹ See Kolodny, Ralph L. and Virginia M. Burns, "Specialized Camping for a Group of Disturbed Adolescent Girls," *Social Work*, 1(April, 1956), No. 2, 81-89.

of several of these youngsters toward an adaptation to camp. Andrea moved slowly in the direction of less suspicion of adults and during the last three days, especially, her belligerence decreased perceptibly. She formed a friendship with an older withdrawn girl from another club, permitted affectionate gestures by counselors, and even made affectionate overtures to them. At the end of the camp period she told her cabin counselor that, although part of her wanted to go, part of her wanted to stay. Despite her resistance and withdrawal, Genie, too, was able to reach out somewhat. She became particularly friendly with two passive youngsters, age 11 and 9. Before she left, Genie told the director that she wanted to stay at camp "forever." Grace, toward the end, came to seek approval through her performance in program activities and gave up acting as flunkie to several older girls, something she had done earlier. She made friends with some of the more passive campers her own age. In contrast to her frequent expression of disappointment with activities during the year, she was able to say that she had enjoyed camp. Even Janine, after seeing her caseworker on visitors' day, seemed to be less overwhelmed by her depressions, although she often appeared quite unhappy. She began to go swimming daily, expressed an interest in doing things for the camp carnival, and participated briefly in a small dramatics group composed of three campers and a counselor. Janine later wrote from home asking if she could some day come back to camp as a counselor. Of all the members, Dolores gave the least evidence of positive change in any respect. She continued throughout to eat sand and dirt and spoke constantly of her fears of height, blood and death. She resisted or was oblivious to routines and activities and occasionally disrupted the latter. She did, however, become

less fearful of undressing in front of others or being seen in the bathroom. She also became less confused in her attempts to distinguish among different people at camp.

Thus, for all its difficulties, and despite its brevity, there were several indications that the camp experience was valuable to the girls. None of them pressed for a return home; the early crisis aspect of the situation was worked through to some extent; some positive behavior emerged as time went on, and all of the girls expressed a desire to return.

It should also be noted that the other campers, with the exception of two very aggressive and provocative girls, were able to tolerate the behavior exhibited by the members of this group. Whatever tension occurred was not expressed through the direct scapegoating of these girls but rather through the displacement of hostility or demanding infantile behavior and never reached an unmanageable level. Open rejection or ridicule of the girls was extremely rare, and many campers imitated staff in their manner of approaching or speaking to them. Occasionally, other campers would try to involve one of these girls in an activity. In a few instances, friendships were made between them. Despite the anxieties aroused by exposure to odd or bizarre behavior, campers seemed to feel fairly comfortable in this setting.

The behavior these girls exhibited during the year which followed the first camp experience was by no means consistent. It varied, of course, from member to member. Much of it, however, appeared to indicate progress. Andrea had her school hours extended after she indicated by her behavior that she could tolerate this. Dolores' bizarre behavior continued, but the school psychologist who tested her every year saw a lessening of some of her paranoid and schizoid tendencies. Although members, individu-

ally, continued to sometimes appear hostile and depressed at meetings and to respond ineptly and inappropriately to events, they were able to function more adequately as a group. They showed themselves capable of taking greater responsibility for planning their own programs. They appeared to make some progress toward being able to talk out rather than act out some of their upset feelings. All of them came to a camp reunion in the fall and Andrea, Grace, and Dolores participated extensively in the singing and games. They spoke of camp often during the year and appeared to look forward to attending again the next summer.

SECOND SUMMER

We realized that, although these girls had profited from the experience in some respects, the gains they had made during the first summer's session were modest, and we were very much aware of the difficulties they had presented to staff. Despite this we decided to bring them to camp a second time.

There were a number of new counselors and many new campers the second summer which meant that once again these girls had to relate to quite a few unfamiliar children and adults.¹² Unlike the previous season, however, in addition to knowing the director well, they were acquainted with five other adults (two supervisors, one counselor, and the cooks). The staff, in turn, contained four people who knew the girls, their problems and capacities, fairly well and who felt relatively sure that their behavior could be managed.

The behavior of these girls during the

second summer indicated that our decision to take them back to camp was a sound one. While tension persisted and was sometimes severe, by and large this was distinctly a more successful session than the first. It appeared that the camp experience was now less stressful for the girls and that some accommodation had taken place. Of course, their behavior was by no means uniformly positive. Many of the maladaptive patterns seen the first summer reappeared, and their reactions were erratic. Attempts at inner control and greater amenability to involvement in camp life, however, were now more in evidence.

Andrea, who, the previous season, had immediately reacted to the stress of camp with violent outbursts of temper and verbal tirades, was initially considerably more subdued. Upon arrival at camp she could not refrain from a few hostile comments, but also asked to see the cooks whom she kissed warmly.

As the camp season progressed, she would often turn to sarcasm when her feelings became too threatening. At the same time, she could directly seek the approval and affection of counselors. It is significant that she did not slap at them as she sometimes had at the beginning of the first summer and instead very frequently sought to hold hands with them. While the violence of her anger was considerably diminished, she was not able to deal too adequately with her ambivalence. Sometimes, for example, she was very affectionate with her cabin counselor, but at other times she would complain that the counselor made her "sick." She could not yet trust her own feelings of affection and had to test out adults to see whether their expressions of positive feelings towards her were genuine. In contrast to the summer before, she was able to evince an interest in contacts with male counselors. She turned to

¹² One of two girls who had been added to the group during the year also came to camp. This was Cynthia, a very large and aggressive 13-year-old who had been and continued to be very difficult to work with.

them for play as eagerly as she did to female counselors and, instead of scornfully disclaiming any concern with males, spoke of the fiancée of one male counselor as "the luckiest girl in the world."

Andrea rarely complained about work assignments the second summer. She griped about extra work details but was able to appear for and carry out regular work assignments. The first summer she had begun by inveigling another youngster into taking her place at dishwashing. She did not repeat this. She did have a tendency to sometimes slip off and avoid work but, when urged by other campers, she worked quite well. She carried out all her assigned tasks and did her part regularly in cleaning the lavatory, sweeping the dormitory and the like, even when she clearly did not want to.

She was ready to participate more readily in camp program and seemed to derive more gratification from the activities despite her continued low frustration tolerance. Her preference was still for individualized activities in which she could play along with the counselor, but she derived some enjoyment from group activities such as singing and occasionally became quite enthusiastic at "sings" during evening programs. She even played the piano for a group on one occasion after volunteering when another youngster was unable to play a particular song. She had never before revealed her ability in this area. Andrea also joined the camp discussion group, which involved sharing ideas and feelings on problems of getting along with others, and was a regular member.

In the beginning, Janine continually sought contacts with counselors and invariably attempted to use these contacts solely for the purpose of discussing her feelings of depression and inadequacy. During the first few days, her communication with

other campers was negligible, and although they said little about this, they did begin to stare at her as she walked about with her head down, obviously quite unhappy.

Despite her deep and persistent depression, Janine did begin to respond more positively in some respects as time went on. She became particularly interested in the camp discussion group led by the director, and as this got underway, she displayed less and less of a need to seek individual conferences with counselors.

On only one occasion did she come close to repeating the distraught behavior of her first two evenings of the summer before. This was on the seventh night of camp when she became panicky after one of her roommates, a youngster from another group, told a frightening mystery story. The director, who was called, was able to quiet her by firmness and reassurance, and Janine did not subsequently repeat this acute behavior, although she was frequently depressed.

Toward the end of the period, Janine found a source of gratification in the camp dramatics group. The previous year she had participated briefly in a small group of three campers who had talked together about dramatics, but her interest had not been sustained. The second summer she joined the new dramatics group and took a prominent part in its activities. Although frequently shaky and fearful of failure, she was willing, with support, to undertake a substantial role in the camp play. In the actual performance she acted well and received much praise from the other campers.

While Dolores' confusion and anxiety were always apparent, her conversation and behavior during the first several days indicated that she was making some kind of conscious effort to change. A number of times she said to counselors, "Last year I did strange things, but now I'm older.

Last year seems like 15 years ago." Except for the first day, when she ate sand once, she did not eat dirt or anything similar for the entire period. She did not play with her food at meals, messing and blowing it about as she had frequently done a year earlier. Although she displayed the same fear of undressing in front of others as she had the first summer, she did not show any particular fear of going to the bathroom. Unlike the year before, it was not necessary to ask other campers to stand guard at the bathroom door to make sure no one would intrude upon her.

For a substantial part of the period Dolores participated better in activities than she had the year before. Although the range of programs she engaged in was still extremely narrow, she did a little individual crafts work on her own initiative and actually participated in some group activities. She enjoyed outings, for example, and joined in now, although not loudly, on singing, whenever it occurred. Although athletics frightened her, she occasionally participated in such things as relay games. There were signs of strain in her behavior during the second half of the period and, after visitors' day, when her family did not appear, she regressed perceptibly, messing more with her food at meals, squinting and staring more often and complaining that others were staring at her. Even then, however, she did not withdraw from activities to the extent that she had the first summer, and she never became disruptive as she had at that time. Surprisingly, Dolores was among those who joined the discussion group. Although her comments were at first focused solely on herself, she later was able to relate to the problems others brought up and to make suggestions for their solution.

In contrast to the summer before, Grace was able to participate in camp life without

first isolating herself. At that time, it will be remembered, she had devoted the larger part of the first two days to working in the kitchen and had taken her meals there. Now she made no move to do so. On visitors' day she actually articulated this new feeling of comfort. When her mother asked her if she had been helping in the kitchen, she said this summer she didn't have to because she "had more friends" and was "having more fun."

Her feelings toward members of her own club group were marked by ambivalence, and her behavior toward them oscillated. For the most part, she was attracted to members of other club groups and even at night expressed a desire to stay in a room occupied by another club. At the same time, in some instances when derogatory remarks were made about members of her own group, she defended their reputations. Most of her contacts with her own club were after lights-out when she joined in heartily on their discussions. Initially, she sought out high status campers and became closely involved with one rather sophisticated-appearing girl with whom she was seen to engage in sexual play on one occasion. By mid-period, however, this youngster and Grace had moved apart without any outside intervention.

Genie's personal appearance continued to reflect her poor self-image, and there was no alteration in her addiction to dirty, masculine attire. She did show change in other respects, however. She participated more in activities, and while she clearly preferred to play alone with a male counselor, she was occasionally willing to play active group games when invited. Toward the end of the camping period she worked very hard at crafts for two days, making two well-constructed ring boxes, one for herself and one for another girl. After the first four days she did not resist being on

time for meals and did not lag far behind the other campers as she had the year before. Although she sometimes complained about work details, she departed from her old pattern by carrying out extra tasks in order to gain attention from counselors.

The actions of some of the members of this group were, naturally, sometimes threatening to others. Campers were worried about Dolores' odd manner and conversation and occasionally expressed anger toward her over such things as her work performance during clean-up. They rarely, if ever, initiated contact with her. Janine's depressed aspect was unpleasant for them. Andrea was resented at times because of her sarcasm, and some campers felt she was being given too much attention by the director.

In general, however, the behavior of the members of this group was not intolerable to the other campers. Grace and Genie developed friendships with girls from other clubs. Occasionally, other campers were protective and supportive toward Dolores, helping her to learn a game or sympathizing with her when she was criticized. The entire cast was openly supportive of Janine and helped her to mobilize herself when she had difficulty during preparation for the camp play. It is particularly noteworthy that the other seven girls in the camp discussion group made plans with Janine, Andrea, and Dolores to have a "social" after camp and also asked if they could meet as a discussion group during the winter.

Assessment of the Experience

In evaluating the overall effect of the camp experience on these girls, the emotional gains must be weighed against the amount of anxiety which the experience itself en-

gendered. There is no doubt that it was a trying experience for them. This was particularly evident during the first year when the shock of separation from familiar surroundings and exposure to a relatively strange milieu initially produced dramatic signs of panic, withdrawal, and aggression. Because of the catastrophic intensity of their reaction, much of their behavior was characterized either by a direct expression of intolerable tensions or a protective avoidance of involvement in camp life. Socialization was, to a large extent, limited to anacletic relationships with counselors. However, clear cut indications of recovery from this initial reaction were seen even during the brief period of their first stay. It seemed highly significant that all had strong reactions to leaving camp and expressed the wish to return the following summer.

Improvements in adaptation to camp were noted during the second summer despite the persistence of disturbed and inappropriate behavior. These girls were able to make wider use of program activities. Disruptive behavior on their part decreased. Their need for individual attention from counselors diminished, and they appeared better able to tolerate limits on their demands for this attention. Although they still had relatively little contact with other campers, three of them were willing and, in some ways, eager to be with other campers in the discussion group. Here, they were able to share the discussion leader with other youngsters, to wait their turn in conversation, and to reveal their personal feelings despite their fantasies of what this might mean in terms of exposure of problems and rejection. All of them, in varying degrees, appeared to have improved in their ability to control impulses, and for long periods they clearly exercised restraint in acting out their feelings. During the

second summer, while they still showed the effects of dislocation, they responded to the demands of camp life with less distress and seemed able to derive more pleasure from the experience.

These girls were able to maintain themselves in the camp situation and improve in their responses to it, because the staff was able to tolerate and manage the acute and distressing reactions they displayed. As a result, while they did precipitate crises, the consequences of these crises were never disastrous, and the outcomes were sometimes emotionally beneficial.

The Management of Crises

For any child there are points of stress in a camp experience which are capable of disrupting his defenses against anxiety and producing disturbances in behavior. These disturbances, however, are usually neither too severe nor frequent and can ordinarily be handled with sympathetic reassurance by counselors who are accustomed to dealing with such minor emotional upsets. Ego-defective children, however, because of their extreme vulnerability, may react catastrophically to the same stresses and precipitate management crises. Since these children have such limited capacity for sublimation, relatively little use can be made of program activities in draining off their anxiety, and this results in extraordinary demands on the counselors. These demands are not only in terms of their time and energy but also in the burden of anxiety that is imposed on them. Counselors must be equipped and willing to face the extreme reactions which accompany ego collapse, including panic, severe depression-extreme regression, and even temporary loss of reality testing. Because of the extreme pressure to which counselors

are subjected, it is essential that they be given a realistic appraisal of the kinds of problems they will face and then provided with the necessary emotional supports by senior staff.

It is possible to reduce the frequency of acute reactions by buffering the ego-defective child from severe psychological shocks through the flexible use of staff and program and alertness to emotional danger signals. Regardless of the amount of planning that goes into the organization of the program, however, it is impossible to eliminate all psychological hazards. The aim of the staff, therefore, should be to reduce the traumatic impact of crises and, through proper management, use them to provide corrective emotional experiences for the child.

Crises can be anticipated around those events in camp life which characteristically increase anxiety such as initial exposure to the setting, being subjected to new routines, the introduction to unfamiliar food, being required to sleep in strange surroundings, and the like. Because of the severe pathological behavior of such youngsters, however, it can be expected that they will overreact to even the minor tensions of camp life.

The examples which follow illustrate the extreme loss of ego-control that can occur in such children as well as their capacity for recovery when given sustained support by someone who is sensitive to their needs:

Paranoid reaction as an outgrowth of religious sensitivity. During the second camp session, Andrea, who is Jewish, complained from time to time that Jewish campers were being discriminated against. Extremely ambivalent toward her own Jewishness and very much concerned with exposure and difference as these related to all aspects of her life, she began to see anti-

Semitism all about her. When the other three Jewish campers did not support her contention, she became more upset. This came to a climax on Friday evening when she became preoccupied about the fact that there was no Jewish service. The following day, Andrea went to the director, who provided her with an opportunity to ventilate her resentments. The intensity of her feelings increased as she talked, and she went on to point out ordinary comments and exchanges of glances on the part of others as being evidences of prejudice; she also bitterly attacked the camp's non-denominational services as discriminatory. She remained adamant in response to the director's unruffled acceptance of her hostility and willingness to make adjustments, maintaining that the administration as well as the other campers were hostile toward Jews. Instead of continuing to deal with this rationally, the director responded to Andrea's feelings of isolation and her fear of surrendering her identity. As a result the fury of Andrea's tirade diminished, and she broke into tears. The director put her arm around her, and Andrea allowed herself to be comforted. The next morning, Andrea went to the non-sectarian service. A Jewish counselor had been delegated to help in planning the service, and the program was arranged with Andrea's complaints in mind. Andrea sat through the entire service, and her only comment on leaving was, "There wasn't anything wrong in that. It couldn't hurt anybody." She was tranquil for the rest of the morning, and there was no recurrence of this particular problem.

Loss of ego-control accompanied by hallucinations. Janine, who had previously been hospitalized with a diagnosis of schizophrenia, managed to control her anxiety during the first day of camp by adopting

a facade of maturity. She came prepared with 10 packages of cigarettes and, cigarette in hand, she affected an urbane manner. On the surface this was so successful that one of the children mistook her for a counselor. The staff was also deceived by her apparent poise, and on the very first night, underestimating her fear of exposure and need for anonymity, ill-advisedly attempted to include her in informal dramatics. This proved too threatening, and Janine fled from the room and remained outside, smoking incessantly, until the activity was over. As bedtime approached, her anxiety increased. She was unable to sleep and sat immobile on her bed. She seemed so tense that the director, who had come into the dormitory, decided to take her out for a walk. She asked Janine if she were homesick and wanted to go home, to which she replied, "I don't know where I want to go." She could only talk about how frightened she was, and the director suggested that she might be afraid that she would break down again. Janine was taken aback at the fact that the director had known she had been hospitalized, and she wanted to know if the other campers were also disturbed. Clenching her hands repeatedly, she began to talk about being a failure, saying that no one liked her or understood her. She said she had no friends so she made them up. She talked about hating her family and, running throughout the rest of the discourse was the theme of hating doctors, because they left her constantly, and liking social workers, because social workers listened to her and helped. She described with intense anguish her fear of being abandoned. The director encouraged her to ventilate her feelings and made it plain that she and staff understood how Janine felt and could accept her behavior. She reassured her they would not punish her by

sending her away from camp. Janine's agitation gradually subsided, and the director was then able to take her back to the cabin where she went to bed.

On the second day, Janine woke up appearing to feel pretty well. She participated in crafts and was able to make some conversation with children at the table although there were periods of depression during the day when she appeared not to hear what was being said to her. That night there was a costume dance, an activity which Janine again found distressing. She did not appear in costume and seemed extremely sad. She said that she was tricked into coming to camp and refused to participate in the activity. Counselors would come over to her to talk with her from time to time, but she would sit blankly as if she did not seem to hear them. Tears started to stream down her face, but outside of this, she exhibited very little affect. By the end of the evening, she was sitting next to her cabin counselor, crying. At bedtime, some of the others in her sleeping quarters tried to console her. She banged her head on the bed and became incoherent and, unlike the night before, did not respond to the director when she came in. She hallucinated, hearing bombs and seeing bad men coming to get her. The director, who was alarmed over the severity of Janine's reaction, called the assistant director and, in Janine's presence, mentioned something about perhaps telephoning the doctor. Janine became even more upset at this and pleaded with her not to call the doctor. She kept asking for her own cabin counselor and did not want the assistant director, a man, around. The director and counselor then sat with Janine. They told her they were not planning to have her hospitalized but wanted to talk with the doctor in order to help her. During this time she kept hallucinating, hearing trains, sirens,

and rain drops. She kept saying, "They don't understand," and, "I'm bad." Janine then indicated that she wanted to go to bed and did so without further ado as long as her counselor stayed with her. She woke up the next day apparently feeling pretty well, although she was concerned that the director would tell her family what she had done. The next day the director called the hospital and conferred with Janine's caseworker. The caseworker agreed with a policy of firm, gentle control and support rather than exploration during such episodes as a basis for handling Janine, without depriving her of the opportunity to ventilate feelings. Janine settled down after this and did not repeat this behavior for the remainder of the period.

Depressive reaction associated with departure. Leave-taking at any camp is accompanied by a rise in tension; tears among girls at these times are not unusual. With deeply disturbed children, however, reactions are likely to be even more extreme. Counselors have to be able to accept without panic or counter-hostility the angry and contradictory behavior that is exhibited. The last morning of camp, for example, Andrea began by helping to make other beds, as well as her own at the counselor's request. Later, however, she refused to carry out her clean-up assignment, which was to sweep the room, and demanded that the counselor do this. She then asked for help with her packing. The counselor responded to this but when she had some difficulty with the lock on Andrea's trunk, this precipitated one of the child's loudest outbursts. She swore at the counselor, saying her mother had had no difficulty with the trunk, and that the counselor was no good. She was very close to tears at this point and left the room. Later in the morning when the campers were let off at the agency in town, the counselor saw her

again. With her mother standing nearby, she embraced the counselor and, as she had done the previous evening, said, "Half of me wants to stay and half of me wants to go."

Janine's feelings of rage at being abandoned began to erupt again as the time for departure approached. On the last day she became openly hostile toward her cabin counselor with whom she had established a good relationship. She would ignore remarks addressed to her in an attempt to hurt the counselor's feelings. She threatened to call the counselor names when it was time to leave camp. At the same time her emotional withdrawal became progressively greater. By evening, she was quite depressed and began to cry, got out of bed and asked for the director. She said she did not want to go home where she would be pulled from all sides and where only her social worker would understand her. Nevertheless, she fell into a sound sleep when the counselor sat with her. She delayed her packing the next morning but managed to control herself until she reached the city. Here, however, she broke down and began to sob. She did not respond to the counselor's questions and continued to cry as she entered the car that was to take her home. Shortly afterwards, she wrote to two counselors saying she had been so happy at camp that she wanted to come back as a junior counselor.

CONCLUSION

Not all disturbed children can be helped by a summer camping experience, even when the camp in question is operated specifically for the purpose of serving children with emotional problems. No matter how well a camp is staffed and organized from a therapeutic standpoint, many youngsters with severe ego-defects may find the de-

mands of camp life intolerable. If the anxiety produced by the experience is too great, it will prevent them from developing any sustained relationships with staff, thereby nullifying the beneficial effects of the program. Furthermore, the amount of individual attention that they require may be so great it will disrupt the operation of the camp and seriously interfere with the activities of fellow campers.

On the other hand, as our findings indicate, if enough caution is exercised in the choice of the children and careful thought is given to their management it is possible, contrary to what has been a commonly held opinion, to integrate even quite seriously disturbed children into selected camping programs. The conditions which we regard as essential to accomplish this task are summarized below:

A. Adequate preparation

Since the initial reaction of deeply disturbed children to being separated from a familiar environment is likely to be so severe, it is important to take measures to reduce its intensity. With the girls we have described it was felt that their previous association in a group and the presence in camp of their leader contributed substantially to their ability to tolerate the camp experience. Where these conditions cannot be duplicated, other forms of preparation must be improvised for facilitating the transition from home to camp. These might include pre-season camp visits for the child, a chance to meet his counselor and other personnel, an opportunity to ventilate his anxieties to his worker or therapist, and the presence of a familiar figure on the trip to camp and the period immediately following arrival.

B. Heterogeneity in camp population

There was a considerable range in the emotional status of the children at our camp. Approximately one-half were free from any serious emotional disturbance. The remainder had emotional problems of various types, but these were less incapacitating than the severe ego disorders of the girls we studied. The nucleus of stable campers was regarded as a distinct asset. Without such children, programming would have been extremely difficult, and demands on counselors would have been correspondingly greater. By their capacity for participation, they served as models for identification for other campers and provided counselors with gratifications which made it easier for them to tolerate the anxieties and frustrations engendered by the more disturbed individuals. However, had there not also been moderately disturbed campers present, the psychological gulf between the normal and seriously disturbed children might have been too great to bridge. The fact that the latter were able to observe that other campers also had difficulties reduced their sense of alienation.

C. Flexibility in programming

Because of the need severely disturbed children have for protective withdrawal, they must be allowed to determine the extent to which they will participate in the camp program. They should be encouraged to engage in camp activities, but demands on them should be kept at a minimum. Materials should be available with which they can work or play individually when they are unable to re-

main in group activities. Regulations at our camp permitted these youngsters to roam about the grounds but within prescribed boundaries. In this connection, of course, a proportionately large staff was a vital necessity so that when one of these girls wandered off, a counselor was on hand to keep her in view, accompany, or work with her. One source of support for these girls may have been in the basic organization of camp activities. During both summers, but particularly during the second, cabin units were not emphasized. Campers were not required to remain with their own cabin-mates for activities. While such a requirement might have made for superficial cohesion, it would have forced members into a consistently close relationship for which they were not ready and would have placed an overwhelming burden on their cabin counselor. If confronted with a persistent demand for cooperative performance as a unit, they might have become upset over their inadequacies in this regard. Instead, although encouraged to come together for some activities, they were each free to move in and out of groups at play as they wished, without being pressured to remain with each other. This kept their responsibility for one another down to a reasonable minimum. It also enabled staff members to share substantially with this group's cabin counselor in the major tasks involved in working with these girls.

D. Unrestricted opportunity for personal contact with staff members

Because of their fear of peer relationships and their feelings of isolation, children with such limited resources

make heavy demands on staff members. They should be permitted to seek out counselors individually for emotional support. The staff must be prepared to accept a high degree of "adult-directed" activity and recognize that these children cannot be pressed into more extensive peer contacts until these can be tolerated emotionally. At the same time, staff members, as they respond to the needs of these children for individual attention, should encourage them to re-establish contact with other campers so that relationships do not become centered exclusively on the exploration of problems on a one-to-one basis. With the girls we have described, to have done otherwise would have played into their pathological tendencies and isolated them further from the central activities of the camp. Our counselors had to be alert to opportunities of all types in bringing these girls individually back into relationships with other youngsters. For example, the discussion group which three of them joined originated in an interview between the director and Janine. As Janine recited her problems, the director pointed out that some of these were shared by other campers who were going through a similar stage of development. She asked Janine whether she would be interested in a discussion group where she and the others could talk over their problems together, and Janine responded to this eagerly. The positive results of this have been described.

E. Professionally trained personnel

It would not be feasible to admit children with such severe ego defects to an overnight camp unless a fairly large

proportion of the staff was experienced in working with emotionally disturbed children. Our own staff included a number of trained social workers with experience of this kind. At that, it took all the understanding, patience, and skill they could command, and at times their own anxiety was all they could tolerate. Among the staff members who returned the second summer, it was the universal feeling that things were easier the second time around. Part of this was because of the improvement in the girls, but there was also the very important advantage of a previous summer's experience, which points up the value of specific camp experience as well as the more general social work background. In addition to having trained personnel on the camp staff, it is essential that psychiatric consultation be available. This is not only vital to the welfare and safety of the children, but also provides necessary reassurance for the staff.

It is important to reiterate that a camp experience should not be regarded as a cure for underlying pathological deviation. If carefully designed, however, it may provide youngsters who have severe ego impairment with the kinds of concrete experiences that will enable them to better manage their impulses and to react with less discomfort and confusion to the requirements of living with others. This seems to us to be especially important in the light of the scarcity of community resources available to such children. Many agencies confronted with seriously disturbed children could consider camping as one way of helping them. They will undoubtedly need to improvise in terms of their own situation, but they should be encouraged by our results to explore this possibility.

Description of a workshop project in mental health

INTRODUCTION

A guidance worker asks, "Have I perhaps been counseling with platitudes and oversimplification?" One teacher questions, "I wonder why our culture doesn't allow an interplay between teacher and pupil for genuine expression of affection?" Another inquires, "Why do I get angry at colleagues who plan an easier program for themselves than I do?" These comments indicate some of the concerns of teachers in a concluding discussion of a course in mental health for educators. The statements also reflect a shift many of the class members had made. At the outset of the course, some of them had confined their attention chiefly to problems in classroom management and student achievement. During the closing sessions, more of them were focusing on the

psychological correlates of behavior, their own as well as that of their pupils.

This workshop project provided an intensive course in mental health for two groups of teachers, one in the fall of 1958, and one for a second group of teachers in the fall of 1959. The project led to many new perspectives in relationships, not only among the class members themselves, but also among the sponsors who had first envisioned the two courses and who gave the undertaking their care and attention throughout the months of preliminary planning, implementation, and later evaluation.

A description of this project, sponsored jointly by the education and scholarship committees of the Morris County (New Jersey) Mental Health Association and the School of Education of Rutgers University, is presented here in the hope that such information will prove useful to other groups interested in similar undertakings.

PRELIMINARY PLANNING

Selection of participants

The decision of the scholarship committee to make the courses available to school personnel was thought to have dual benefits. In the first place, the orientation of a key professional group such as this to new development and resources in mental health held promise for its becoming better informed and better able to contribute to the community's understanding and acceptance of responsibility for mental health problems. Secondly, it was considered that an educational group would have unique opportunities to draw upon mental health concepts in its direct contacts with large numbers of children and youth in the schools and as a consequence of a course such as this, would be more likely to foster healthy personality development in their pupils.

The members of the 1958 class were selected by their superintendent or principal and sent as a delegation from their school system. The members of the 1959 class applied voluntarily and were selected in such a way as to obtain countywide geographical representation and a membership representative of the various specializations within education. These included nursery school, kindergarten, elementary and secondary teachers of private and public schools, nurses, administrators and guidance counselors.

Although it is universally recognized that educators have a strategic role in the development of good mental health in their students, teacher preparation for this role is a fairly new function in the training institutions. Teachers who received their training prior to the early 1950's often lack any substantial work in psychology. Teachers who have been graduated more recently are faced with many unknowns in

their day-to-day dealings, even though they have had appropriate academic courses. A number of writers have called attention to the critical importance of in-service training in this area whether it be to provide a practical supplement to undergraduate work in mental hygiene, or, as is frequently the case, to furnish teachers with new insights into the emotional development of their pupils. Kanzer (1) says, "The introduction and development of psychological insights among teachers is one of the most important problems of prophylactic psychiatry." Stouffer (2) also calls attention to this point of view when he states, "There must be continued instruction of the teacher in the dynamics of child behavior. New knowledge must continually be a part of the teacher's understanding and approach to the child." Bernard (3) feels that "Many of the teachers who have the readiness for and the capacity to merge mental health concepts, as taught by clinicians, into their own educational approach are often able to enhance the effectiveness of their teaching through access to in-service opportunities, and these should by all means be extended. Stevenson (4) regards teachers as being in a position to "buffer some of the adverse influences that bear upon the child. They are in a position to provide a good atmosphere within the school that can counterbalance the reverse at home and in the neighborhood. The least that one can expect of the school is that it should not hurt the child further, and to this end that it should take into account that children differ and need different kinds of help from school."

Plan of the workshop

Once the committee had designated the educational group as the appropriate recipient of the workshop project, it then

called upon the School of Education of Rutgers University of New Jersey for assistance in the planning, organization, and instructional aspects.¹

It was decided to offer the courses on a graduate credit basis for eight weekly double sessions, each an hour and forty minutes in length, with an hour between the sessions for dinner served on the premises.

A number of outstanding professional leaders engaged in some phase of mental health work were to talk during the afternoon sessions of the classes and act as discussion leaders. These persons included two psychiatrists, two psychologists, a school social worker, a school counselor, a former school administrator, and a prominent professional lecturer in family relations. The evening meetings were to follow the theme of the afternoon ones with a topical presentation by the instructor and additional class discussion. At one meeting during the first course a group of parents was also to present its views on ways parents might assist teachers in understanding children. At both courses, the sponsors were to talk briefly on activities, publications, and resources of the county, state, and national mental health associations.

Topics of the sessions were to include the following: (1) Meanings of mental health and its importance in the life of teachers and students; (2) Personal and cultural bases of personality development; (3) Identifying symptoms of emotional health and ill health in children; (4) The relationship of anxiety, hostility, and authority problems to a child's development; (5) Under-

standing and dealing with behavior and learning difficulties in children; (6) The limitations and potentials of the teacher's role in assisting healthy emotional growth in children; and (7) School and community resources for improving mental health in children.

Costs of the workshop

The costs of the workshop project were originally planned to be carried in their entirety by the Morris County Mental Health Association. However, as an outcome of the joint planning which evolved between the committee and the school systems in the county, the association financed the tuition costs of the students and the honorarium paid the speakers. Registration fees and books were paid for by the local school systems in some instances and by the students themselves in other instances. The university paid the salary and travel expenses of the instructor.

Evaluation of the workshop

The obstacles to evaluation of mental health programs are familiar to anyone concerned with research in this area. Nevertheless, it was decided to try to obtain two measures of change: (1) Analysis of subjective judgments made by the class members themselves in a weekly log or final summary paper relative to new knowledge and understandings gained during the course; and (2) Comparison of pre- and post-test scores of the two class groups (1958 and 1959) on expressed attitudes toward children as measured by the Minnesota Teacher Attitude Inventory. The second course also used a control group made up of teachers in the county who were not enrolled in the course but who took the tests at the same time as the course participants.

¹ Dr. Robert Poppendieck, then director of administrative services in the School of Education at Rutgers, and now specialist in teacher education for the U. S. Office of Health, Education, and Welfare, was largely responsible for this stage of the planning.

THE PROCESS

As is often the case in a pilot endeavor, the ending would make a good beginning. Since the courses were exploratory in nature, a clarification of purposes and process occurred throughout which could well form the nucleus of future workshops. The instructor trimmed some of her sails of aspiration as did the participants. The class members progressed from discomfort at the lack of specific assignments and tests, through a period of uneasy trust in freedom, to achievement of some very meaningful individual analyses of particular problems in their lives or in their teaching. A backward glance in some detail may serve to highlight the learnings from the standpoint of both the instructor and the students.

The instructor

The instructor's previous experience had consisted of elementary classroom teaching, clinical work with children and parents, and the teaching of developmental psychology courses to teachers. She saw in this project some unique opportunities for teachers to learn about themselves as well as about their students, and to increase their understandings of behavior on an emotional as well as an intellectual level. Achievement of such goals required her, then, to consider both course content and instructional methods.

In reference to the content of a course in mental health, it appears that inevitably there is some overlapping of insights and understandings common to the subject matter contained in psychology and the problems dealt with in psychotherapy. For a classroom teacher to understand that a child's destructive acts may be caused by negative feelings about himself or others instead of being merely "bad behavior" is

an important first step in being helpful to a child. If the teacher has sufficient background to understand some of the theoretical formulations regarding the origins of anxiety, hostility, guilt, and the like, she may be even more effective in supplying some of the child's needs or in recognizing his incapacity for accepting what he most needs. To the extent that the teacher has become aware of her own negative feelings and defenses, she has a special bridge for understanding the disturbed child. And the deeper the teacher's understanding of the origins of her own feelings, of course, the more free she is to see the child's situation clearly with a minimum of distortion caused by her own problems. Practically, then, the content of these courses was viewed in two dimensions: an intellectual extension of information about child behavior, and an emotional extension of understanding in instances where students were able to grasp some of the personal meaning of the content.

In reference to the instructional role, the courses also seemed to require a combination of therapeutic and educational understandings although the primary function was seen as instructional. Bernard (3) describes the interconnection in this way: "The clinician-instructor (of in-service teacher education groups in mental health) must steer a middle course between the pitfalls of trying to bring about psychodynamic understanding in an emotional vacuum, since this cannot lead to understanding, or letting the interpersonal situation slide into an inappropriate, uncontrolled, quasi-therapeutic morass."

This middle road was not difficult for the instructor to follow when it involved presenting concepts *about* mental health and psychodynamics, or when it called for a clarification and elaboration of the presentations made by the speakers on the basis

of comments and questions raised by the students. Its direction was less clear when class members expressed attitudes which appeared to reflect unconscious resistance to threatening material. To avoid the implications of such issues as the presence of aggressive impulses in nearly everyone, the likelihood of both love and hate characterizing a close relationship, and the benefits of recognition rather than denial of feelings, the class members often drew upon what Chisholm (5) called the—"binding certainties imposed in childhood" governing respect for authority, the rights of the group, and the need for firm discipline. In these instances, the instructor usually accepted and restated the expressed reactions as being one person's point of view at that time, often not interpreting further or raising questions, except as class members did. This posed the problem of whether some of the psychodynamic understanding which was a goal of the two courses was being lost in the retreat to a more didactic emphasis. At the conclusion of the courses, it appeared to the instructor that such procedures had led to some emotional insights on the part of some class members but probably to a strengthening of intellectual defenses on the part of others. And perhaps this is par for such a course, as it probably is for any human experience.

Certain barriers to achievement of an understanding of mental health concepts, other than content and method, persisted throughout the courses, and were seen more clearly at the conclusion than when the courses were in progress:

1. The tendency of teachers to seek a solution to a child's problem before searching for an understanding of it;
2. Their tendency to focus only on a child's disruptive behavior and ways

to modify it rather than examining their own reactions and feelings toward the child;

3. Their tendency to veer away from the unpleasant realities of problems in their own life and the lives of others and to adhere to an ideal of what life *should* be rather than what it is;
4. Their tendency to expect a great deal of themselves as teachers, to be all things to all children, to have a profound and even "curative" effect on every child; and
5. Their tendency to want to fix everything up so it will be all right rather than facing the insecurities within themselves, attempting to understand and handle them, and then helping children to do the same.

The students

The participants in the courses described in their evaluations some of their reactions and learnings and in individual instances attempted to account for them. The following material, with their permission, was drawn from their final evaluation sessions, one of which was recorded, from a reunion of one class five months after its last session, and from their final summary papers.

Both groups commented favorably on the learning climate of the courses. They appeared to be particularly appreciative of such an opportunity being given them, not only that the costs were taken care of for them in most instances, but that the topics, speakers, assignments, and time schedule had been worked out with special reference to their interests, needs, and responsibilities. Professional attention might profitably be directed to giving teachers more assistance and encouragement of this kind.

While the two groups suggested having

fewer speakers at forthcoming workshops or making use of panel presentations by several speakers at the same meeting, the issues raised by the speakers formed much of the substance of the courses. Those mentioned most frequently were as follows:

- (1) Confidentiality of psychological reports;
- (2) Long-term nature of behavioral change;
- (3) Limits of treatment results;
- (4) Preliminary considerations in accepting a child for psychotherapy;
- (5) Dangers of labeling a child adversely;
- (6) Usefulness of anecdotal descriptions when a child is referred for diagnosis or therapy;
- (7) Problems in communication among professional workers about a child;
- (8) Relevancy of anxiety and hostility to the educational process;
- (9) Importance of early identification of emotional

problems; and (10) Availability of assistance for teachers in dealing with disturbed children and for the children themselves.

An objective evaluation

The Minnesota Teacher Attitude Inventory was administered to the class participants in each of the two courses, before and after being enrolled in the course. A control group was used in the second course made up of teachers in the same county school system selected individually by each course member as being similar to himself in attitudes toward children. The control group took the tests at approximately the same time as did those enrolled in the course.

The MTAI is designed, according to its authors, to measure those expressed atti-

A statistical comparison of pre- and post-test scores made by three teacher groups on the Minnesota Teacher Attitude Inventory in conjunction with a course in mental health

	N	MEAN	SD	S-D	t
I. 1958 Class Members					
A. Scores BEFORE Taking Course	25	39.40	27.20		
B. Scores AFTER Taking Course	25	45.10	31.00	5.13	2.33*
II. 1959 Class Members					
A. Scores BEFORE Taking Course	26	47.20	21.20		
B. Scores AFTER Taking Course	26	62.20	19.20	4.5	3.14**
III. 1959 Control Group					
A. FIRST Scores	19	41.24	27.51		
B. SECOND Scores	19	43.26	30.34	.05	1.07

* Significant at the .05 level of confidence.

** Significant at the .01 level of confidence.

tudes of teachers toward school work and children which are said to be indicative of how well a teacher gets along with pupils in interpersonal relations and, indirectly, how well satisfied the teacher is with teaching as a vocation. A validity coefficient on Form A of the test of .59 was obtained when test results were correlated with T-score averages of three outside criteria of teacher-pupil rapport as evaluated by principals, pupils, and experts. A reliability coefficient using the split-half Spearman-Brown was .93. These figures are reported in the test manual.

For use in the workshop project then, a null hypothesis was assumed, namely, that there would be no change in the attitudes of class members toward children and teaching as measured by the MTAI before and after their enrollment in a course in mental health.

RESULTS

On the basis of application of a t-test of significance to the difference between pre- and post-test scores of class members, the null hypothesis for both groups in the workshop project can be rejected. In other words, a change in scores as great as occurred between the pre- and post-tests of the class members in both the 1958 and the 1959 courses would be likely to occur, by chance, only five times in a hundred or less. Such changes in scores, to the extent that these scores can be assumed to be an outgrowth of reading, discussion, lectures, and instruction occurring within the framework of the workshop project, can be regarded as one type of evidence that such an experience was valuable to teachers in changing their attitudes in a positive direction toward children and teaching.

The fact that the control group showed no difference between its initial and final test scores lends support to the above conclusions. However, it must be borne in mind that such expressed teacher-pupil attitudes as measured by the tests are probably simply indicators of the teacher's attitudes and may not reflect actual changes in behavior within the classroom.

CONCLUSION

This report has described the preliminary planning, procedures, and evaluation of a workshop project in mental health for teachers sponsored jointly by the education and scholarship committees of the Morris County (New Jersey) Mental Health Association and the School of Education of Rutgers University. Its outcomes might be summarized graphically by a statement made by one of the participants:

"I've learned to be more realistic about children, that they are different, each one, and that there is no pat solution, no easy answer that can be applied in all cases. But more than that, I've found for the first time in a college course that *I* count, too. Either I didn't even think about myself, or I just blamed myself when things went wrong, instead of giving myself some of the credit and some of the understanding that I think is so important for children."

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The legal profession as a member of the psychiatric team

Traditionally, the psychiatric team has consisted of psychiatrists, social workers, nurses, and psychologists. However, it is another group, the legal profession, which, often has the initial contact with a mentally ill person or his family and thus has much to contribute in the treatment of mental illness. Members of the legal profession and its ancillary branches can make a significant contribution to the care of the mentally ill, provided their approach to the proposed patient or his family is therapeutically oriented. Process in therapy begins prior to actual hospitalization of the patient. The person or persons who have the

first contact with the patient or his family establish the emotional climate and set the stage for treatment. In many instances, the first professional person to whom the family turns when a relative becomes mentally ill is a member of the legal profession or of the enforcement agencies, such as the police, sheriff, etc. The importance of this initial contact has been long overlooked by the legal profession and by other professions directly involved in the care of the mentally ill.

Most frequently the legal profession is consulted when the family is considering a commitment to a state hospital. Statistics are not readily available to indicate the number of patients hospitalized as a result of a legal commitment, but Kittrie (1) states that more than a quarter of a million new patients are admitted each year through legal channels. Therefore, it becomes obvious that all professions involved in the care of the mentally ill should be

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vitaly interested in the medical-legal aspects of commitment.

Commitment laws vary from state to state, and the simplicity or complexity of the laws range from a single half-page document to a lengthy treatise, thus making the medical-legal picture more complicated. In an effort to clarify commitment procedures and to achieve some unification, a Draft Act was written under the auspices of the Federal Security Agency in 1949 (2).

In the Draft Act an attempt was made to focus on the specific questions which needed to be answered before determining commitment and to eliminate from legal consideration those matters which are degrading, harmful, or not pertinent to the person's state of mental health. For instance, the consideration of the financial circumstances is unnecessary at the time of commitment. There should not be an equating of incompetence and the need for mental hospital care. The use of a lay jury is undesirable and, often, insistence that the patient be present during the hearing is detrimental to him.

Recently at the Ninth Mental Hospital Institute (3), a section was devoted to the discussion of commitment laws, and there was general agreement upon the following points:

All parties involved should be primarily concerned with the patient and the trauma he suffers during the procedure and, at the same time be concerned with protecting his legal rights. Publicity, police custody, and detention in jail should be avoided. The stigma should be removed from commitment, and involuntary hospitalization should not be restricted to those considered dangerous to themselves or someone else but should be available to those in need of treatment who, because of their illness, lack sufficient insight to make application. Voluntary admission is always to be pre-

ferred since the patient's involvement in the process helps him to accept more readily and to participate more fully in therapy. Lastly, procedures based upon the criminal law should be abandoned.

Slowly, state legislatures are abandoning archaic procedures and adopting new, more humane commitment laws. Utah was one of the first states to make legislative changes consistent with the Draft Act of the Federal Security Agency. A committee under the able leadership of Dr. C. H. Hardin Branch, Judge William S. Dunford, and Judge Joseph G. Jeppson¹ proposed to the legislature a commitment law based on the model draft act. A law which incorporated this model act was passed in May, 1951. Since then, commitment hearings have become a part of the treatment process and less traumatic to patients and their families.

Specific points from the Utah State Code (4) illustrate the incorporation within the law of a therapeutic and humane attitude towards the proposed patient:

"The State Insane Asylum now established and located at Provo, in the County of Utah, State of Utah, shall be known as the Utah State Hospital.

..."

"Upon receipt of an application, the court shall give notice thereof to the proposed patient, to his legal guardian, if any, and to his spouse, parents, and nearest known other relative or friend. If, however, the court has reason to believe that notice would be likely to be injurious to the proposed patient, notice to him may be omitted. . . ."

"The patient, applicant, and all other persons to whom notice is required are given an opportunity to appear at the hearing. . . . The hearing shall be conducted in as informal a manner as may be considered (consistent) with orderly procedure and in a physical setting not likely to have

¹ Dr. C. H. Hardin Branch, head and professor, Department of Psychiatry, College of Medicine, University of Utah; William S. Dunford, Judge, Fourth District Court, state of Utah, deceased; Joseph G. Jeppson, Judge, Third District Court, state of Utah.

a harmful effect on the mental health of the proposed patient. . . ."

"While awaiting the judicial hearing, prior to his removal to the Utah State Hospital, he may be detained in a hospital, foster home, nursing home, etc., or any place which is under the jurisdiction of the Department of Public Welfare. He shall not, except because of, and during an extreme emergency, be detained in a non-medical facility used for the detention of individuals charged with or convicted of penal offenses. . . ."

"A committed patient shall be entitled to communicate by sealed mail or otherwise with persons, including official agencies, inside or outside the hospital, to receive visitors and to exercise all civil rights, including the right to dispose of property, execute instruments, make purchases, enter contractual relationships and vote, unless he has been adjudicated incompetent and has not been restored to legal capacity."

Granted that no law is better than the persons administering it, the Utah law does provide certain conditions and privileges which are bound to be beneficial to a patient. As a result of this structure, a patient maintains a sense of responsibility for himself and views hospitalization as a step towards regaining his health.

There are four methods by which a patient may be admitted to the Utah State Hospital and for purposes of clarification, a brief review of these provisions follows:

First, the patient may be admitted on a voluntary basis, which is desirable under most circumstances. The patient may, if sixteen years of age or older, sign himself into the hospital. If the patient is under age sixteen, his parents or guardian may sign the admission form. This means the patient is free to leave the institution at any time upon written request and should this occur prior to the time the superintendent deems it desirable, he (the superintendent) has 48 hours in which to act on the request. If he believes the patient is a danger to himself or someone else, he can file a petition with the local district court asking for a hearing on the case. While

awaiting the hearing, the superintendent has the authority to detain the patient in the hospital.

Secondly, a patient may be admitted on a voluntary-involuntary basis, more correctly known as the standard nonjudicial method. In this instance, a relative or friend makes the application on behalf of the patient, since the patient is unable to carry out the procedure because of his illness; two doctors designated as examiners by the Welfare Commission examine him and certify his need for hospitalization. This procedure is helpful in handling a patient who is moderately resistant to hospitalization but who will accept such planning once others have taken the necessary steps for admission. Similar to a voluntary admission, a patient can request release from the hospital and must be granted his written request unless the superintendent obtains legal authority to detain him.

An emergency procedure is used only in extreme situations and is the third method. A health officer, or police officer facing an emergency may place the patient in the hospital immediately either with or without the endorsement of a judge. This method is the least acceptable or desirable and is used rarely and then only in the case of a violent or dangerous patient. This procedure must be restricted to emergencies since there is no medical examination of a condition which warrants medical concern.

The fourth and last method is the involuntary or commitment procedure. This process may be initiated by a friend or relative who goes to the county clerk's office in the area in which the patient resides to give information to the county attorney substantiating the need for hospitalization. If the patient has seen a physician recently, a medical certificate is included in the application. However, if the patient

refuses to submit to a medical examination, a paragraph is endorsed stating his unwillingness to cooperate. When he receives the information, the county attorney draws up the document and submits it to the judge for his signature. After reviewing the material, the judge issues an order designating two certified physicians to examine the patient. If, in the opinion of the family or friend, the patient is likely to do harm to himself or to another while awaiting the examination, the judge can issue an order detaining the patient in a hospital for observation prior to the date set for the hearing. The patient is brought to a psychiatric unit in a general hospital, and a complete evaluation is done. This process involves interviewing the person who signed the affidavit to further clarify the information given to the county attorney. The patient is seen by the two designated examiners, and the result of this examination is submitted on an official form to the court. If, following the psychiatric examination, there is no need to hospitalize the patient, the judge can be so notified, and the case is dismissed immediately without a hearing. If, however, the case needs to come before the judge for commitment to the state hospital, a date for the hearing is then set through the county clerk's office. The law requires a five day legal notice prior to the hearing. Since the law provides that such hearings shall be held in a physical setting not considered harmful to the patient, they are always held at the General Hospital in Salt Lake County. This setting is less disturbing to the patient than the court room which tends to associate mental illness with criminality. Only those immediately involved, such as medical and social work personnel of the hospital, legal counsel, members of the family and close friends are permitted to be present at

the hearing. The emphasis throughout the commitment process is on the medical problem rather than its legal connotation. Since the inception of the 1951 commitment law, lawyers involved in commitments have become adept in helping the patient accept that which is best for his mental health. If desirable, the patient attends the hearing, but he is not compelled to do so. However, most patients are urged to appear so they may feel they have participated in the decision.

Because of the nature of the Utah commitment law, and because the intent of the law is to facilitate treatment, the judge is patient-focused and often helps the patient to recognize hospitalization as a necessary medical rather than punitive procedure. Excerpts from case records may serve to illustrate the therapeutic atmosphere of the court.

Mrs. S. was a thirty-five-year-old woman who was signed into the hospital on application by her husband. She was the mother of three children and had been acutely disturbed for the past three months. She had difficulty in caring for her children and her home, because she was becoming more preoccupied with her delusional thinking. The physicians examined her and diagnosed her illness as a schizophrenic reaction, paranoid type. In their report, which the judge had read, they recommended hospitalization at the Utah State Hospital for an indefinite period of time.

At the commitment hearing, the judge told the patient, "The purpose of this hearing is to determine if you need hospitalization." The patient's response was that she did not think she needed it. The judge then asked, "Don't you think people at the hospital can help you?" With reluctance, the patient indicated that they might be able to do so. The judge pointed out, "Very often

people who are mentally ill don't realize it. From the evidence presented to the court I would have to commit you unless you have some doctors to say you are not ill." The patient said she had no such evidence. "If you were a judge and two doctors said you were ill, while you said you weren't, how would you decide? Do you see the difference in the weight of evidence?" The patient indicated she could, and the judge continued, "I can continue this matter a week for you to get a doctor to testify in your behalf, or you can acquiesce and immediately start treatment. If I were in your situation I believe I'd accept the medical viewpoint. What do you wish to do—decide today or have a week's delay?" The patient stated she would accept whatever he thought best. "Based on the evidence given by the doctors, it is the judgment of the court that you are mentally ill and should be committed to the state hospital. Good luck to you." The hearing was concluded.

Mr. B. was a twenty-nine-year-old single male who had been chronically disturbed but recently had become unmanageable at home because he was acting out his delusional ideas. His parents had found it increasingly difficult to get him to eat properly or to have enough sleep. The doctors diagnosed him as a chronic schizophrenic and recommended hospitalization.

At the hearing the judge instructed the patient that it was necessary to determine whether or not he needed hospital treatment. The young man doubted that he needed it and the judge stated, "The doctors here think that if you took some treatment in a hospital you'd get well and again be able to enjoy things." The patient expressed his interest in clerical work and added that he had enjoyed his previous employment. The judge responded to the patient, "I believe if you had some treat-

ment you'd be able to return to work." The patient wanted to again enjoy things and indicated an acceptance of whatever was necessary. "Then it's acceptable to you to receive hospital treatment." The patient nodded his approval, and the hearing was concluded.

These brief excerpts from the records demonstrate the attempt made by the judge to involve the patient in the decision. Most patients accept the recommendation of the court, and their response is directly related to the sincere efforts on the part of the judge to be an active participant on the psychiatric team assisting in the treatment program. Without question, the judge's judicial position has significance to the patient, and when the judge uses his position of authority in a constructive manner, he makes a unique contribution to the treatment of the mentally ill. No other member of the team carries the degree of authority represented by the judge. When used correctly, this authority can have beneficial effects on the patient.

Should the patient object to the psychiatric recommendation, he is given one week in which to gather evidence which will support his plea for dismissal of the case. He is informed that a psychiatrist or medical doctor testifying in his behalf will be the most pertinent evidence he can present. Frequently, the patient returns the following week having decided he will accept the recommendation of the physicians and the decision of the court.

At all times the final decision on commitment rests with the judge, who generally acts on the medical recommendation. If, at any point, the judge disagrees with the physicians, it is his prerogative to do so. Occasionally, he will decide to commit a patient because the individual in his opinion is a social menace. In some of these

instances, the patient is unlikely to respond to treatment, and hospitalization has questionable value as a therapeutic measure but has specific value as a protective one.

The single question before the court is whether the patient is mentally ill and is therefore in need of hospitalization. There are two reasons for involuntary commitment to the Utah State Hospital. Either the patient is mentally ill and lacks sufficient insight to make application for himself or he is a danger to himself or others. These are the only legal justifications for action. However, within these limitations the judge can exercise considerable flexibility and interpret the law broadly to benefit many patients previously denied hospital treatment.

The question of competency is not a part of the commitment hearing and rarely is raised unless the patient is diagnosed as having an organic brain syndrome, a chronic type from which he will never recover. Should it be assumed that the individual is incompetent and in need of a legal guardian, a separate hearing is held in the district court. At this hearing, the evidence and testimony must bear upon the patient's competency or lack of competency, and physicians may be called to testify as expert witnesses.

Members of the patient's family are not asked to testify under oath unless there is disagreement with the physician's recommendation or dissension among the family. If the relatives do not give formal testimony, the patient can continue to feel as though his family and friends have been loyal to him and had not taken part in an action which initially feels wrong or punitive. This course of action is particularly helpful when handling a paranoid patient who views everyone as his enemy. Hospital personnel try to prepare both the patient and his family for the medical recommen-

dation which has been forwarded to the judge, thus reducing the amount of emotional turmoil experienced on the day of the hearing.

Borderline cases present the greatest difficulty for all professional people concerned and cause the most severe disagreements among them. The course of action for the individual who is overtly psychotic or for the one who has sustained permanent organic brain damage is clear cut, but the patient who at times is in contact with reality while at other times is grossly disturbed causes physicians, lawyers, and judges grave concern. Doctors have, by virtue of their training, knowledge which assists them in planning a medically sound treatment program, but, frequently, lawyers and judges have only a layman's understanding of these problems. During the past few years, lawyers and judges in Utah have been expressing an increasing interest in psychiatric knowledge. With the passing of time, it is becoming more the rule rather than the exception that lawyers and judges involved in commitment hearings possess a fair understanding of psychiatric diagnosis and the probable course of treatment. As their knowledge increases, it becomes easier for physicians and lawyers to agree on the best plan for the patient's mental health.

On initial examination, the Utah law may seem to many persons, especially to members of the legal profession, to be too broad. However, professional people, including members of the legal group, who have worked with the provisions of the law have found it generally to be beneficial to patients and their families. The law has not been abused, and the credit for such must be extended to the officials administering it. In 1952, a year after the Utah legislature adopted the new commitment law, Branch (5) conducted a brief survey of those most directly concerned with it to ascertain

their opinion regarding its advantages or disadvantages. Approximately 86 per cent of those responding thought the new law a significant improvement. However, there were those, mainly judges and lawyers, who had some reservations. This latter group believed the law made it too easy to commit a patient to the hospital and expressed concern that the individual's rights be disregarded. These are some of the same concerns expressed by members of the American Bar Association and reported by Kittrie in his article, "Justice for the Mentally Ill" (1). Clearly, the ideal law in final form has not been written. This situation is recognized by the American Bar Foundation which has assumed as one of its first projects the study of mental illness and the legal entanglements. Only since 1954 has the legal profession begun expressing an interest in the legal problems of the mentally ill. Enlightened physicians do not want a patient denied his civil rights, and

the legal profession recognizes the need for humane, medically sound procedures. The present procedure is imperfect, but it is indisputable that cooperative action among all professional groups offers the patient the healthiest possible future.

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ROBERT L. LEON, M.D.

A participant-directed experience as a method of psychiatric teaching and consultation

This report will illustrate the learning of psychiatric concepts through the interchange of feelings, attitudes, and information in a democratic group setting. We show how, by clear and adequate communication, a group of health workers was able to move toward the solution of problems of interpersonal relationships. These problems arose out of efforts of Public Health Service personnel to meet the health needs of American Indians, but similar problems must be resolved in any health program.

Two consultants, a psychiatrist and a psychiatric social worker, met in 11 monthly sessions with a group of physicians, medical social workers, and other personnel stationed by the Public Health Service on widely scattered Indian reservations or in towns near these reservations. This group of approximately 18 members assembled with the consultants at a central location

once a month for sessions which ran from 1:30 to 5:00 P.M., and 8:30 A.M. to 12 noon the following morning. Approximately one-half of the group were physicians; four were medical social workers, and there was, in addition, an anthropologist, a public health nurse, and a public health educator.

A request for consultation was initiated because of the recognized need for mental health services for Indians. Since sufficient personnel was not available to allow trained mental health workers to participate directly in a service program, a consultation program was thought to be the best beginning step.

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Psychiatric consultation and training for physicians and other health workers in isolated areas remains a great problem in this as well as other countries. Universities offer post-graduate courses usually in central locations or offer occasional lectures in outlying areas. With some exceptions, however, the teaching has been of a didactic nature.

Smith (1) *et al.*, in their program to train general practitioners in the treatment of chronic alcoholics, were able to allow for a good deal of participation by the trainee. The program of Watters and Atkinson (2) has much small group participation.

Balint (3), on the other hand, provides for a discussion of feelings on the part of the physician in a small group setting as one of the major elements of a program to train general practitioners in the use of doctor-patient relationships.

We do not believe the didactic method is the most suitable in the teaching of psychiatric and psychological concepts at the postgraduate level. Rather we believe, as does Cantor (4), that learning is a dynamic process in which the student must struggle with problems and move toward a reorganization of the self. Balint (3), whose book was published during the time the author's consultation program was in progress, states that "the acquisition of psychotherapeutic skill (among general practitioners) does not consist only of learning something new, it inevitably also entails a limited, though considerable change in the doctor's personality."

The consultants' conviction, then, that learning in the consultation process could only take place through participation by group members within a permissive relationship, in effect, gave the initial structure to the group. The consultants set the limits for their own participation. The group was free to set goals, select topics,

and otherwise determine the direction and nature of the discussion. The group was not, however, free to place the consultants in an authoritarian position. A group leader was picked from among the physicians. The consultants were thus free to serve as resource people.

At the first meeting the group was told that psychiatric consultation would be available and that the group was free to determine, within limits, how to use this consultation. There seemed to be two schools of thought at the early meetings as to what was expected from consultation. Some felt the sessions could take the form of group therapy, whereas others wanted the consultant to tell them how to handle neurotic and psychotic patients. The consultant relieved considerable anxiety by discussing the difference between consultation and group therapy. He further stated that it was not his purpose or desire to solve the participant's personal problems.

The group members decided to begin the series of meetings by bringing specific problems involving patients with psychiatric or emotional disorders. Later, as participants became more comfortable, more general, less well-defined problems that the physicians were having in inter-staff relationships or physician-patient relationships were brought for discussion. In the first several sessions specific information on the handling of psychiatric patients was requested. As is often true in the beginning of a consultation process, cases of severe psychoses or severe organic brain damage were presented to test the consultant or, in the case of some group members, to prove that the consultation could be of no value. These cases were used, however, to illustrate basic human motivation even though helpful recommendations many times could not be made. Most of the group members soon dropped this sort of testing, but it

persisted with one or two members well into the sixth and seventh sessions. Those who presented these severe and difficult problems were the ones who felt the most need to "take something back" to the reservation and were the very same group members who found it extremely difficult to become emotionally involved with the group. One of the doctors who early expressed the need for much factual information later began feeling comfortable enough to present material from interviews with patients. At the end of the 12-month period, when the sessions were being evaluated by the group to determine whether or not the program was to continue, this same physician stated that he believed that the doctor's attitudes and feelings affect the treatment of his patients, it was, therefore, important and justified to give the doctor the opportunity to explore feelings and better understand himself. This physician probably presented the most dramatic example of change.

The need to understand Indian culture as different from the cultural patterns of the participants, physician and social workers, was also present. Here the anthropologist was quite helpful in presenting the needed clarifications. Early in the sessions, much time was spent discussing the subject of cultural differences. As the doctors felt more free to understand their own feelings, and as they became more comfortable in dealing with the emotions of others, there was less talk of Indians being "different." The discussion shifted to emotions common to all people. For example, in the first meeting it was brought out that the Indian's concept of time differs from that of middle-class non-Indians. Among other things, he lives more for the moment; he is not too concerned about appointments made in the future. If he has a severe illness, such as tuberculosis, he

apparently does not want to spend sufficient time in the hospital to rid himself of the disease. By the third session, the doctors had learned from the Indians themselves their feelings about tuberculosis and about many of the hospital procedures. These feelings were appropriate and understandable in terms of the disease and the situation. The attitudes expressed by the doctors then shifted. Indians were no longer looked upon as being radically different. It was evident that behavior of Indians could not be explained on the basis of simple, stereotyped, cultural differences.

The material presented for discussion during the course of the year can be grouped under three headings: (1) problems presented to the doctor or social worker by an individual patient; (2) institutional problems, that is, problems of patient-staff interaction in Indian boarding schools, in the tuberculosis hospital, and in the general hospitals on the reservations; and (3) staff interrelationships and administrative problems. As to be expected, these areas overlap somewhat.

The following are examples of patient problems which were presented. A five-year-old girl with otitis media was brought into the clinic by her mother. During examination and treatment for the otitis, the physician found the girl could not or would not talk beyond saying a few simple words. Her mother was questioned about the child's talking and immediately became anxious and excited. She gave little additional information and refused help for the speech problem in her child. She expressed much fear that the child would be taken away. The mother said that she would take care of the problem herself with the help of God. Her refusal to accept help plus her anxiety and excitement prompted the physician to request help

from the medical social worker. The social worker learned that the mother had deserted the child in infancy and had recently taken her back. It was further learned that members of the community in which the mother resided were afraid of the mother. She was described as excitable and paranoid. The social worker wanted to know how he could handle the problem and how he could gain entrance into the home.

The entire group entered into the discussion. Although there was not sufficient information from which to draw definite conclusions, the psychiatrist was able to discuss the anxiety underlying the mother's behavior. He pointed out that the rejection of help was probably a defense mechanism protecting against underlying guilt or other conflicts. The major contribution of the other group members, however, was to discuss with the social worker his own anxiety and frustration over not being able to help this mother and child. The social worker was better able to accept this discussion of his own feelings from the group than he would have been from the consultants alone. It then became apparent to the worker, as well as to the other members of the group, that the worker's anxiety had prevented the development of a tentative plan of action.

A woman in her sixties came to the clinic complaining of pain in her foot. She was hospitalized overnight for study, and diagnosis was made of peripheral vascular disease. The woman was advised that she would have to remain in the hospital for prolonged treatment, and that amputation of the foot might be necessary. The urgency of the situation was presented to the patient and her daughter who had accompanied her. The woman spoke very little English so the daughter acted as an interpreter. The woman stayed in the hos-

pital three days and left against the physician's advice. It was subsequently learned that she had gone to a private hospital in a town near the reservation. There two amputations were performed at successively higher levels on the leg, but the stump did not heal. At the request of the physician in the private hospital, she was returned to the reservation hospital where she had first been admitted. A third amputation was performed. Good healing of the stump resulted. The physician who presented the case felt that the woman left the hospital against medical advice because she was not aware of the severity of her illness. The doctor stated that he felt inadequate because he could not get the woman to accept the necessity of remaining in the hospital for treatment. As a result of his own feelings of inadequacy and frustration, he pressed harder and harder and presented the medical picture to the woman with more and more urgency. Significantly, however, he did not allow the woman to express her feelings about being hospitalized. Entirely through chance, the anthropologist had talked with the woman's husband at his home on the reservation. The husband described the wife's illness and related the history of her medical care. The husband said that he and his wife had been satisfied with the care that she had received at the reservation hospital. Indeed, he even complimented the doctors. He told the anthropologist that this was the first time that he and his wife had ever been separated in their 40 years of marriage. When she had first entered the hospital, they were both extremely lonely, and this was the reason she returned home.

This case probably presented one of the best examples of how disturbed communication can occur in the physician-patient relationship. Through the husband we learned the patient's motivation. The doc-

tor had clearly expressed his own opinions and feelings as to why the patient acted as she did, but his inferences regarding the patient's motivation were incorrect. This case also illustrates our thesis that learning and insights best occurred when motivations and feelings of all parties concerned were understood and expressed. The doctor, because of his own anxieties, had not allowed the patient to express her feelings.

Many institutional problems were brought for discussion. One of the most meaningful, however, again related to the expression of feelings, this time on the part of the Indians who had been hospitalized.

It had been routine for the staff of the tuberculous hospital to periodically lecture to the Indians on tuberculosis. The staff would give a general discussion of the disease and discuss prophylactic and other health measures. This was usually done in the auditorium with the Indian patients in the audience and the physicians and other staff members on the stage. As a result, partly at least, of the increased interest in feelings of patients stimulated by these consultation sessions, the staff of the hospital decided to reverse the situation. The Indians were asked to go onto the stage, and the staff sat in the audience. With the help of an interpreter, these Indians then told the staff their own feelings about tuberculosis, how they felt about being in the hospital, and how they had felt when they were first told they had the disease. For example, the Indians reported that they felt insulted if the doctor was not tactful in telling them they were infectious to other members of their family. Some Indians felt the doctor was accusing them of wanting to harm other family members. This apparently was quite an emotional experience for both Indian patients and house staff. As a result, many hospital policies, rules, and regulations were changed. Pa-

tients' emotional needs were more adequately met. Following these changes, the number of patients who left the hospital against medical advice dropped sharply.

The discussion of the administrative problems centered for the most part around the physician who discussed his difficulties relating to nurses, Indian sanitarians, and other such people in the hospitals or in the field health service teams on the reservations. Some of the physicians on the reservations were young doctors who were experiencing administrative problems for the first time. Here again, when the physician could clearly express his anxieties and hostilities to the personnel working under him, he could reach some sort of solution for his problems. One situation brought for discussion was that of a physician who was unable to get his nursing staff to carry out the kind of program he wanted. The physician spent most of an afternoon discussing his own feelings and inadequacies but was able to move no further. He could not accept help and suggestions from the group nor could he convey much more than the feeling that he felt anxious and frightened. The group tended to become irritable since the doctor could obviously not resolve his own neurotic problems, and the general discussion ended rather unsatisfactorily.

DISCUSSION

The consultation program, as it progressed, represented the dynamic interaction of a number of complex variables. For the purpose of discussion, we will separate some of these variables which we feel contributed significantly to the favorable outcome. In this regard, two constellations or groups of factors seem to merit equal consideration.

The first group of factors relates to the setting, the composition of the group, the administrative support for the program,

and the common purpose and goals of the participants. The group was dedicated to the common goal of improving health services to Indians. The need for developing mental health services for Indians was recognized by staff at both service and administrative levels.¹ There was thus a high level of motivation on the part of the participants. Most of the participants had worked together at one time or another on the reservations or in the central office, but since the reservations were widely scattered, there was little opportunity for social or professional intercourse. Thus, the monthly meetings presented a welcome opportunity for the participants to get together.

The composition of the group deserves special attention. Most of the group members had volunteered for work with the Division of Indian Health, so that they were there as a result of a process of self-selection. This tended to set up a kind of homogeneous group which was further pulled together by common goals.

The second constellation of factors relates to group structure and group process. The nature of the democratic group process with participants selecting topics for discussion has already been described. The most important element of the group process was the more or less free discussion of feelings on the part of group members. When the feelings and motivations of individual members could be clearly understood, problem solving occurred. If these feelings could not be discussed in some way or another, and at times this discussion was indirect, then adequate communication failed to occur within the group and also between the doctor and his patient.

The exchange, recognition, and exami-

nation of feelings within the group takes courage on the part of group members, including the group leader. All manner of psychological defenses come into play to prevent the examination of feelings. These defenses are to be respected. They are rarely, if ever, approached directly. Rather, each group member must be allowed to keep his defenses intact until such time as he can comfortably allow others to glimpse behind them. Or, to state the matter more simply, group members were asked, but not forced, to examine their own feelings as they related to matters under discussion.

One particular aspect of the consultant's role should be emphasized. Although the consultants felt they had a contribution to make, they recognized that they did not know the nature of the problems to be met by Indian Health Service staff. This was verbalized to the group so that members understood that the consultants were also present to learn. Group members were thus given further responsibility for participating in the discussion.

CONCLUSION

We have here a tool, among many, of considerable value to the promotion of mental health and the attack on mental illness. We submit that a program, as outlined above, is useful in the training of general practitioners and other health workers. We do not feel that the main focus should be to achieve skill in psychotherapy. Rather, the focus should be on the doctor's relationship with his patient in all areas of medical practice.

SUMMARY

We have described here a psychiatric consultation program with Public Health Service personnel working with the Division of Indian Health. We show by the use of case

¹ We feel that the wholehearted support of the administrative staff was one of the crucial factors.

material how the learning of psychiatric concepts takes place through the exchange of feelings, attitudes, and information in a democratic group process. Factors believed to be responsible for the favorable outcome of the program are discussed.

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But little do men perceive what solitude is, and how far it extendeth. For a crowd is not company, and faces are but a gallery of pictures, and talk but a tinkling cymbal, where there is no love.—Francis Bacon, 1607

Suicide

Part 4

PART 4: PREDICTABILITY AND PREVENTION

There are no more precise predictors in the matter of suicide than in accidents, alcoholism, delinquency, drug addiction, or divorce. But each shares with the other suggestive signs which can serve as channel markers in the passage leading to the ultimate crisis or catastrophe. Psychiatry offers insight and clues derived from studies of the dynamics of the suicidal process in which suicidal fantasies, communications, and attempts have been the

central features of evaluation. In our epidemiologically-oriented studies (1, 2, 3) further clues have been, and are being, sought not only through the enumeration of demographic characteristics of the successful suicide, the agents used, and the environment in which the act was undertaken, but in the interplay of the factors. Even at this early date additional marker buoys are beginning to make their appearance in the suicidal channel which may be of value in prognosis and prevention.

It is possible to make a few broad generalizations about the suicide before detailing certain precise characteristics about him, his environment, and the agents he employs which may be of significance in the process. The subcritical mass of sui-

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cide, to borrow a phrase from atomic physics, is to be found in a persuasively large number of cases in the confluence of at least three host factors—loss, aggression, and depression. These constitute the core of *dynamic host factors*. In the absence of the LAD syndrome (4) apparently relatively few suicides take place. Yet the conversion of the subcritical to a critical mass is often triggered by the most innocuous of events.

While all three "subcritical" factors mark the suicidal channel, depression has special importance. Even for the medically untrained person, its prime features are recognizable. They may be found in preoccupation with one's health and chronic complaints about aches and pains with no apparent reason, reduced energy output, increasing blandness of interest, or lack of interest and feeling tone. There are other clues: disturbed sleep or frank insomnia. In combination they soon express themselves in increasingly tense, nervous reactions, loss of appetite, loss of weight, and various gastrointestinal symptoms.

Often there is a general letdown in interests and drives. Pleasurable pursuits are reduced or abandoned one after another. There is often a curious mood flux. No matter how poorly they may feel, no matter how despondent, people in depression will say they feel fine. Occasionally, however, you will get a straight answer—"I feel real lousy," or "rotten," or "I cannot begin to tell you quite how I feel."

Whether precipitate or calculatedly deliberate, there is an overwhelming body of evidence to suggest that the suicide is rarely a rational being eliminating himself for thoroughly valid reasons. More often than not, he is emotionally and often physically ill.

In a series of 134 suicides recently studied

in St. Louis (5), 101 were found to be suffering from one of five specific psychiatric illnesses; five were suffering from terminal medical illnesses (without concomitant psychiatric disease); three were apparently clinically well, and twenty-five were undoubtedly psychiatrically ill although specific diagnoses could not be made. Thus, 98 per cent of the total group were clinically ill, 94 per cent psychiatrically, and 4 per cent, medically. Sixty-eight per cent of those who were psychiatrically ill were found to be suffering from one of two diseases, either manic-depressive psychosis or chronic alcoholism. (In view of our earlier discussion of the significance of depression it is interesting to note in these groups that the suicidal act is rarely if ever undertaken in any but the depressive stage.)

A breakdown of selective symptoms and other historical data in 60 people in this series (those with diagnosed manic-depressive disease who later suicided) displays the prevalence which might give them some prognostic value. (See table on following page.)

In fact, this breakdown, particularly items (d) through (f), might serve as a useful check-list of prognostic host factors in non manic-depressive suicides. But there are other dynamically-important host factors. The patient's pre-suicidal pattern may include a meaningful group, including preoccupation with death and the desire to die, frequent and recurrent communication of suicidal ideas in general or specific statements of intent, and, in fact, actual attempts. These may not be accurate predictors but they may mark the suicide-prone with even greater accuracy than the accident-prone can be spotted. Part of the folklore of suicide posits that people who threaten suicide do not. The tragic fact is that they often do, and we would do well,

Item	Per cent
(a) Clinically well, exclusive of attacks of manic-depressive disease	69
(b) Previous episode of manic-depressive disease	46
(c) Discreteness of present attack. Duration of present attack:	
6 months or less	57
12 months or less ¹	87
(d) "Medical" symptoms: ²	
Insomnia	88
Anorexia	82
Weight loss	80
Low energy, weakness	74
Fatigue	71
Constipation	28
(e) Psychological symptoms:	
Blue, depressed, sad	97
Diminished motor activity	77
Loss of interest	72
Diminished sexual interest and activity	61
Undertalkative	59
Low expectancy of recovery;	
"black" future	53
Feeling of being a burden	44
Indecisiveness	44
Feeling of worthlessness or marked guilt	40
Agitation	38
Personal untidiness	32
Difficulty in thinking and concentration	31
Delusions	27
(f) Disturbances in social behavior. Decreased social and recreational activity	77
(g) Miscellaneous items	
Age of onset, 40 and over ³	75
Family history of manic-depressive disease	26

¹ Only 13 per cent of the cases had a duration of the present attack greater than one year. The maximum duration (one case) was four years.

² Other "medical" symptoms, such as headache, palpitation, dyspnea, dizzy spells, abdominal pain, and vomiting, which occur with a high frequency in manic-depressive disease, are not listed here because they are less specific in helping to differentiate this illness from other psychiatric diseases. They are, however, important in the recognition of and in the total clinical picture of manic-depressive depression.

³ Age of onset is the age at the time of the first reported attack of manic-depressive disease.

therefore, to hear and to heed their ideas, their fantasies, their threats. In the St. Louis study (7), 68 per cent communicated suicidal ideas, and 38 per cent specifically stated that they intended to kill themselves. The corresponding figures for alcoholics were 77 per cent and 61 per cent.

Among the demographic host factors of special significance are age, sex, marital and religious status. In an earlier report it was pointed out that the suicide rate in the United States rises steadily from its low point in youth to a disturbingly high point in age groups over 75. In general, our figures for New York City over a 25-year period (1929-1954) follow this overall trend. Crocetti's (8) median of 49.7 years for successful suicides approximates ours. But he points out, interestingly enough, that the median for unsuccessful attempters was 31.7 years.

In the prediction and prevention of suicide, the age factor may have particular meaning for two groups, the young and the old. First, it must be remembered that the prime cause of death in children age 0-5 are accidents. The proportion of these which are truly accidental is overwhelmingly large. It is more than mere speculation to state that quite a number are not so accidental. While the predominant agents involved in true accidents in children are ingested toxic substances, purposive accidents like suicides rarely involve ingestions. Such acts are generally characterized by extreme violence.

According to Bender and Schilder (9), the methods used by children in their suicidal wishes and attempts involve jumping out of a window, which is the simplest way out, cutting one's self, stabbing, hanging, and even running in front of speeding automobiles. Only older children tend to ingest poisons.

If the impression that children who suicide are essentially creatures of violence is confirmed by studies presently underway, basic precautions would then have to be directed against violent forms of self-extinction rather than the more adult method of ingesting toxic substances.

Spite is an overtly expressed emotion in threatened, attempted, and successful suicides in the young. As a consequence, strong, hostile, and aggressive emotions expressed by children should be observed carefully and critically, their causes ascertained and eliminated where possible, and, if impossible, then controlled.

Depressions associated with separation from parents or loved ones is another important factor in suicidal attempts in the young. Separation may be in fact only temporary or may be complete, as in death. But if viewed as permanent or irrevocable, it may be highly traumatizing and may precipitate a suicidal attempt.

During adolescence, in particular, when young people appear to be in a constant state of flux and when there are marked shifts in mood and the rapid and sometimes violent appearance of anxiety and tension states, suicide may be attempted as the means of resolving what appear to be unresolvable problems.

The tensions of teen-agers require a good deal more than the casual dismissal by adults that they will pass. They do, sometimes taking the teen-agers with them. The categorical "firm hand" response similarly is often no more profitable. This is the time when good medical care in general and psychological care in particular are the most effective forms of sound suicide prevention.

At the other extreme of life, we find people who appear to be psychobiological organisms in repose or decline, slowing or slowed down in functions, in interests, in activities, and in relationships. One would

almost expect as a sequential extension of these characteristics that when elderly people suicide, they would do so in a manner reflecting such patterns and dispositions. To be sure, some of them do, often by taking lethal quantities of hypnotic drugs, but a good many die violently.

The outlook for elderly people who attempt suicide but do not succeed generally is not very good. Reports of both British (10) and American (11) psychiatrists indicate that 12 per cent of those who attempt suicide in old age will make a second try and succeed within two years. This is, of course, much higher than repeat performances of younger people.

As we have already pointed out (12), there is a wide range in the suicide rates among the sexes. Crocetti found that among "successful suicides, 68 per cent were male and 32 per cent female; among the known attempted suicides, these proportions were exactly reversed. In other words, 68 per cent of those attempting suicide were female, and 32 per cent were (13) male." The ratios among successful suicides, and attempters will range, according to age, up to 4 or 5 males to 1 female. What conclusions, if any, can be drawn from these observations? Two, I think. First, that against the backdrop of LAD, the communication of suicidal ideas and other dynamic factors, men suicide with a frequency at least twice and often four times that of women. And second, when they attempt suicide, because of their intent, motive, or method, they are more likely to be more successful than women.

Finally, among the demographic and environmental host factors of importance in the suiciding process are those involving relational systems. The stronger these systems the less the likelihood that suicide will occur. Susceptibility to suicide is lowest among those who have strong family,

work, church, and community relationships. Crocetti's observations that: "Suicide was proportionally (on a rate basis) more frequent among the unmarried (single, widowed, and divorced) than among the married, . . . attempts at suicide, on the other hand, were relatively more frequent among the married" (14) are supported in the many demographic, sociologic, and psychiatric studies previously reported (15).

Among the environmental factors impinging with particular strength upon the suicidal process, the ones bearing upon the L in the LAD syndrome—loss, loneliness, and aloneness—seem to have special importance. Sociologic study after study point up the fact that there is a consistently higher incidence of suicide among people who are homeless or transient, who live in transient (non-residential) areas, or who live alone. Their loneliness and aloneness is further accentuated in the weakness or absence of relational roots other than in the family, such as occupational, community, church, or recreational activities.

Time of day, season of the year, even anniversary of death may be regarded as environmental factors of some importance in emphasizing one's aloneness and loss. A number of sociological studies point up the fact that when even homeless and transient people cease to huddle together—usually a winter phenomenon—there is an increase in the suicide rates in this group. Psychiatrists have noted the low point, in a sense the most alone point, for depressed patients is in the early morning, especially between 5 A.M. and 7 A.M. The weather phenomenon, controversial though it may be, is persuasively related to suicide. Here again, there have been consistent observations of the increase in incidence of suicide among depressed people who apparently are further depressed by a drop in barometric

pressure, leaden skies, storms, and unremitting winds (16).

Finally, the "anniversary syndrome" (17) has implications for suicides. The anniversary, generally, but not always, of sad events—the broken engagement, the divorce, but especially death—is a potent suicidal trigger. The anniversary of the death of a loved one is a special lides for depressives of all ages, male or female. Two antipodal phenomena have been generally observed in this matter. In some cases, as the anniversary date approaches, there may be no overt recognition, no mention of the fact by the person in the depression. This may be a warning sign in itself. The suicide-to-be may go about his business as usual. Then, on the anniversary—and it is almost always on the date or on the day of the week itself—self-execution! In other cases, there is a steady deepening of the depression, climaxing in suicide on the anniversary date or day.

A knowledge of the methods and means of self-extermination, of their frequency and typicity (if any), of the reasons why, and the conditions under which some people chose certain methods and others do not, may not get at the root causes of suicide but may be extremely helpful as guides in prevention. Basically, this is the reason for their inclusion in this series (18).

Suicide, as we have seen, is rarely an impulsive, highly agitated, unpremeditated act. It is generally a well-defined, deliberate act. In summation, therefore, the frequency and consistency with which the following host factors make their appearance in the suicide process suggest that even if they cannot be regarded as precise predictors they must be considered in programs of prevention and treatment:

1. The LAD syndrome is an important pre-condition of the suicide;

2. Many suicides have an antecedent history of emotional and physical illness;
3. There is an overwhelming pattern of preoccupation with death and the desire to die, frequent and recurrent communication of suicidal ideas and fantasies, specific statements of intent and repeated attempts;
4. The incidence of suicide increases precipitously with increasing age;
5. There appear to be age and sex specific patterns of suiciding against which appropriate measures may be taken;
6. Susceptibility to suicide is lowest among those who have strong family ties, church, work, and community relationships.
 - a. The unmarried (single, widowed, and divorced) generally have higher suicide rates than married people.
7. Time, season, and weather conditions appear to influence suicide rates.
 - a. For people in depression, the early morning hours may be critical from a suicidal point of view.
 - b. A drop in barometric pressures and other weather conditions are often associated with an increased incidence of suicide; and
8. The anniversary syndrome may be a real trigger mechanism for those who are depressed and potentially suicidal.

While positive management of these factors may be helpful in programs of prevention and treatment, there are several things experience has taught that one should not do.

It is improvident to take lightly even what appears to be casual talk about suicide. The various fantasies and ideas, or more specific statements of intent, should not be considered as idle words and should

be taken with the utmost seriousness. In this particular case, good prevention can be built much more effectively on the conservative notion that people with such ideas more often than not mean them and far too often implement them.

The medically unsophisticated person will do well to take a leaf from the book of the experts in their evaluation of depression and in their handling of people in profound states of despair and despondency. These are conditions which call for unusually expert skill, and it can be both a serious and a dangerous mistake for this condition to be considered lightly. Such superficial attempts as argument, cajoling, teasing, or jollying the patient is not only ineffective but, in fact, may increase his depression and make him feel the futility of his existence all the more. In Ostow's study of depression, he seriously questions the hospitalization of people in such states because "the very fact of removing him from his home and job to be hospitalized may make him sufficiently desperate to pass from suicidal fantasy to suicide itself (19)."

Miller, Fellner, and Greenfield (20) wisely suggest that when hospitalization seems indicated, it should be in that type of institution with experience in dealing with depressed patients where the personnel are sensitively geared to deal with suicidal attempts. Obviously, in such institutions, maximum security measures may be taken against suicide, but perhaps equally important is the awareness on the part of the staff that premature discharge is a *sine qua non* of prevention.

In the St. Louis series (21), 10 patients in the main diagnostic psychiatric groups killed themselves within eight months after discharge from a psychiatric hospital.

It is an unusually common experience that when depressives show sudden im-

provement, suicide may be even more of a possibility than when the depression is in full swing. Miller *et al.*, therefore urge the physician "to convey to his patient that he understands how badly the latter feels. A sense of isolation is very dangerous for the depressed person. . . . In no case should the patient leave the physician's office without being given a definite return appointment. Because of the sleeplessness and agitation usual in this condition, there is a timeless quality present and the patient should not be left for a long period to his own devices . . . if the physician [and the family] waits until the depressed patient's suicidal intentions are abundantly clear, he may have waited too long." (22)

Families of depressed, pre-suicidal patients have a most difficult role to play, particularly when they are aware of the problems and dangers implicit in the situation. The repetitive and deepening quality of the problem may be one of their greatest frustrations, for they will see that, despite their most heroic efforts to make the depressed patient feel important and loved and wanted as a participating member of the family, he may not respond. Too often and tragically, this failure in response leads to resentment, anger, and hopelessness, and families must guard against this in themselves in precisely the same way that they would hold such reactions as unworthy if the patient were suffering from a broken leg or cancer. However dismally their efforts are greeted, they must try to maintain in the depressed person the feeling of being wanted. There are no pat formulae for doing this. It is certain that it cannot be done solely by constant verbal assurances of affection and regard for the patient's status and worth. It must be done, even more importantly, by the "doing" method. Among other things, this would call for meticulous attention to problems

of physical well-being, for as Miller and his associates point out ". . . certain physical illnesses are notoriously depressant in effect, pancreatic disease, i.e. chronic pancreatitis or carcinoma of the body of the pancreas, brain tumor, and toxic states in association with bromides, barbiturates and *Rauwolfia* . . ." (23). Integration or reintegration into the family constellation by having these patients participate in family councils and activities is a much stronger means of re-establishing their status and worth than talking about it. This is particularly true of elderly people. Recreation and other organized time-fillers for this group must be found. For both young and old the discovery or rediscovery of religion may be enormously important.

As a basic rule, medical help is indicated long before the clues to suicide cluster. But suicide prevention and control is a burden that cannot be borne by the medical profession alone. Suicide prevention is everyone's business, and the sooner the recognition that suicide is more than a final fact but a long process with many prominent and measurable antecedents, the greater is the likelihood that much can be done to prevent it.

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LEONARD T. MAHOLICK, M.D.

Responsibilities and functions of community mental health centers

Any community mental health center that purports to affect individual and community mental health positively has the inescapable responsibility for developing three basic programs: (1) a clinical program which would "treat the sick;" (2) a broad, community-wide program sufficient in scope to involve the community in treating its own illnesses; and (3) a research program which evaluates both the clinical and community programs and also contributes knowledge to the behavioral sciences (1). The need to relieve suffering is immediate and obvious. However, we should not forget that the sick

individual does not exist in a vacuum. Many forces besides his immediate family are at work molding and influencing his personality. These include educators, physicians, clergymen, lawyers, politicians, civic and industrial leaders, the executive, legislative, and judicial bodies, and other key agencies and institutions. How to reach them and translate our specific knowledge so that it can be used constructively by these groups and how to influence them and help mobilize their forces to create the kind of society which favors good adjustment and is dedicated to human needs and values should be of vital concern to every center. The fact that these problems are so vast and complex, that our methods and techniques leave much to be desired and validated, and that our current knowledge is so limited is justification enough to devote a considerable amount of time to research. In my presentation it is to be remem-

Dr. Maholick, who is medical director of The Bradley Center, Inc., in Columbus, Georgia, presented this report as the keynote address at the January, 1959, Topeka, Kan., Workshop on Community Mental Health Centers, sponsored by the Kansas State Board of Health, the National Institute of Mental Health, and the Community Mental Health Centers in Kansas.

bered that I am speaking from the vantage point of being in a private, nonprofit, foundation-sponsored center. Having had training, leadership responsibility, and consultative experiences in community and public health clinics, I feel I am now in a position to look a little more objectively at where I have been and what I have done. These experiences have allowed me to note some differences and make comparisons. I trust that I will be able to focus sharply enough on some problem areas that will be of value here.

When the center arrives on the community scene, it will cause and be subject to many reactions stemming from a host of sources including unrealistic treatment expectations, excessive demands for diagnostic, treatment, and testing services, difficult, chronic, unsolved problem cases that agencies are unable to cope with and are anxious to get rid of, resistance to psychiatric treatment, and personal, professional, and agency jealousies, competitiveness, and other conflicts. Therefore, how the early phase of the center's development is handled is most important, for its very life, how it functions later, and the place it evolves for itself in the community can be dependent upon it.

Some of these problems can be minimized by making it clear that the center is but a single agency designed to do a specific job, and is no panacea for all of the problems of the mentally ill (2). The setting of the agency, its auspices, and general objectives should also be defined before the doors are opened. As soon as the professional staff arrives, policies and procedures should be written out in detail, understood, and accepted by the staff and its governing board. This gives the staff a sense of security and purpose and helps them weather the pressures that will be placed on them later. Thorough, well-defined policies also enable

the center to keep pressure on the community for dealing with problems not covered by them. Used this way, they can be an effective tool to prevent complacency from developing after the "clinic team" has arrived. Since the center has responsibilities for developing three basic programs, it would be well at the outset to weight them and set aside a specific amount of time for each program. This, too, gives security to the staff and helps orient the center to the community.

I CLINICAL PROGRAM

Mental and emotional illnesses are the concern and basic responsibility of the professionally trained clinician. There is no escaping the fact that the community has relegated this authority to the center. How this is translated into action, however, varies widely and is an expression of the uniqueness of each individual center. Since the center's primary reason for being is to help people (3), the first task would be to develop efficient, flexible, sound, high-quality, clinical practices, and therapeutic skills. I sometimes wonder if any staff should venture very far into other activities until these goals have been achieved.

I believe firmly that the emotionally disturbed person is an agent of emotional contagion, and when he is treated effectively, the disease is prevented from spreading. There are no good reasons why priority should not be given to those cases where prognoses are most favorable and where the length of treatment is predictably short. The aim of every center should be to treat as many cases successfully per year as possible. This enables the center to have more contacts in the community which should help many individuals achieve their maximum social therapeutic potential (4). Key individuals treated successfully at the right time can be responsible for social changes

that not only are difficult to measure but, more importantly, to match. For example, one patient and her understanding husband were essentially responsible for my remaining in Columbus when I was at my lowest ebb, ready to concede defeat, and planning to move to greener pastures. This patient, now successfully treated, carried her story far and wide. More patients came. They did the same. I stayed. The news filtered back to families, relatives, friends, physicians, and to other social groups. Anxiety about receiving psychiatric treatment was markedly reduced as a result. Interest in the field was stimulated. Another patient is in many ways responsible for the establishment of our own center. I am sure these things and many others came about because of patients, and I doubt very much if talks, lectures, or panel discussions could ever have matched what they did individually. Let's not ever forget our basic responsibility—the patient. Using these policies obviates the very real problem some centers have of getting lost in their therapeutic pink clouds, treating fewer and fewer sicker individuals, and isolating themselves from the rest of the community (5). The achievement of these clinical goals boosts staff morale and gives them a sense of accomplishment and productiveness. The board will be pleased because they can see that "something is being done." In addition, the community will eventually accord the center its due professional respect and acceptance.

Although psychotherapy has become the most frequently used therapeutic tool in clinical practice, we should not forget that it is but one of many therapeutic tools available to the patient. Neither should we get grandiose ideas about psychotherapy, for it has real limitations, both as regard application and effectiveness. These limitations, however, should not cause us to

retreat from our clinical responsibilities, avoid them, or take flight into frenzied community activities.

Intake policies and procedures need to be scrutinized, defined clearly, and redefined at regularly scheduled intervals at least by the professional staff and preferably by both the staff and board (6). Do we really appreciate what the prospective patient goes through? Are we a hard-to-get-to or an easy-to-reach clinic (7)? Let us look at what frequently happens to the patient as he goes through the intake routine. A telephone call is made asking for help, which is followed by a long waiting period for an initial appointment or appointments with the psychiatric social worker. The patient then is interviewed by the psychologist and still later by the psychiatrist. Conferences are held about the patient and, finally, a disposition is made. If he fits the bill, he is honored with acceptance for treatment only to be placed on a long waiting list! How stuck are we with rigid, time-honored procedures? Can we be flexible enough to adapt them to meet patient needs more effectively and efficiently? I am afraid there also is a tendency to become complacent about long waiting periods for initial consultations and waiting lists for therapy. I doubt if we have spent much energy in improving current treatment methods or inventing new ones. How much have we explored group therapy, for example? It has all sorts of possibilities. And what of our sacred cow—the 50-minute-hour? If we could find ways and means to reduce this to an effective 30-minute therapeutic appointment, we could, at one blow, double our therapeutic resources. I also question whether our current supervision methods really serve their purposes effectively. Are there better, more realistic and efficient methods to be tried? How many members of the clinic team have the slightest notion of what it

actually costs to treat a patient in the clinic setting using present methods? I am sure there are many other pertinent, searching questions we could ask ourselves. We should not shrink from them; rather, they should stimulate us to look for and find better solutions.

We were forced to do just that at the Bradley Center. Most of our patients come from the middle-class group, can afford to pay some fee for services, and want to do so. In demanding high-quality, efficient services, they placed new pressures on us and forced us to examine our conventional procedures for intake, diagnosis, disposition, and treatment planning. While I do believe our solutions have implications for all mental health centers, I am not suggesting they could or should be tried elsewhere, nor am I making any pretense to have found "the answers," but I should like to share our experiences and results with you for whatever they are worth.

Trouble came from several sources. First, our primary source of referrals (physicians) complained of losing direct contact with the consulting physician and objected to their patients being seen initially by a non-medical person, since most of them had already made and completed preliminary diagnostic studies, saw the need for treatment, and made the referral on this basis. Second, our patients became impatient with long waiting periods and delays in arriving at a disposition, duplication, and complained, usually indirectly, of not seeing the psychiatrist first. Third, we became concerned about our own inefficiency in meeting patients' needs, rigidity, costs, and unnecessary wastage of good professional time. For three years, we experimented with some variations still based, however, on conventional methods. Finally, we decided to set up a research project to evaluate our methods. Through the use of questionnaires

and ratings by both the staff and our patients, we found that many of our intake procedures actually contributed little to final diagnosis and treatment planning while they consumed excessive time and money. The results of our study, additional unfruitful clinical experiences, and considerable thought forced us, in July, 1958, to make some radical changes to streamline services. Our secretaries were trained to take calls, get pertinent information on printed forms, give appointments, and orient patients as to what to expect. The psychiatrist took sole responsibility for diagnosis, disposition, and treatment planning. Other staff members were used as consultants, and only when specifically indicated. For most patients this meant fewer visits to the center (usually one), less confusing contacts with the staff, and rapid disposition. As we have learned to coordinate our efforts, we have approached the efficiency and directness of service of the private practitioner.

Still later, research gave our clinical services a second shot-in-the-arm from an unexpected direction. Our major research focus has been in the area of conducting mental health evaluations with nonpsychiatric populations. In this work we request our subjects to fill out a Biographical Questionnaire, a Mooney Problem Check List, a Cornell Index, and an MMPI. It occurred to us to use these with our new patients. They now present us with unexcelled data which is analyzed before applicants are seen. Patient response has remained consistently enthusiastic. The initial consultation is a much more intense, pointed, and productive contact as a result of this additional modification which enables us, in one hour, to formulate a reliable diagnostic impression, appraise resistances and defenses, prescribe a form of treatment or make other dispositions on the spot, discuss fees, and assign the patient to a staff member for

psychotherapy as indicated—with ease and sureness.

The need to do something about our waiting list for therapy stimulated us to experiment with a broad group psychotherapy program. We have had as many as five different groups operating each week. Consequently, it is possible to place a new patient in one of the groups immediately if individual time is not available from a staff member. Just recently we ventured into a program of group counseling for parents of our young patients. We also have been using half-hour therapeutic sessions with excellent results.

After wrestling with these problems during the past four years, we think we have arrived at something that is practical, productive, and efficient. Our sources of referral seem to like it. Our patients like it. And the staff is satisfied, too. As a result of using these new methods and experimenting with others, we have been able to release a minimum of 12 professional man hours per week for other purposes. We are seeing more people in therapy. The waiting period for initial contact seldom goes over two weeks, and emergency time is available. We are spending over 80 per cent of our clinical time rendering individual and group psychotherapy currently. A great deal of burdensome dictation has been eliminated with a corresponding reduction in clerical work. This, along with other modifications in supervision and weekly psychotherapeutic progress reports, has enabled us to eliminate the services of a half-time typist. Although we are pleased with the results of our efforts thus far, there is still need for continuing study and evaluation.

The possibilities still are limitless, and the future is very bright. I foresee the increasing therapeutic use of the telephone and the development of two-way television con-

tacts for both individual and group psychotherapy—both designed to bring help to people in remote areas. It is not at all inconceivable that in the not-too-distant future we will be able to give reliable "mail-order" diagnostic and treatment planning evaluations. The best is yet to come.

II COMMUNITY PROGRAMS

Many of us believe that health, and, in this specific instance, mental health, is not only the responsibility of every individual but also of the total community. Therefore, we would see the center function as but one social agent among others sharing this heavy load, yet making its own unique contributions in the following five areas:

(1) *Education*

Unfortunately, a lack of understanding and acceptance of mental and emotional problems still exists. The dissemination of sound, basic mental health information is important. However, the best way to do this and the effectiveness of our techniques still remain a secret. To what extent the center should become involved and what the hoped-for goals should be need to be defined carefully.

(2) *Supervision and Consultation*

Community agencies, key individuals, and other groups touch the life of the individual at different critical periods. Hence, they are in a position to influence and redirect him. They can be helped to do a more effective job through the use of these services. However, agencies, especially, often are prone to want direct services for their clients in preference to anything else. If the center accepted referrals from them passively, it could easily pauperize the agencies professionally by relieving them of their responsibilities. It would be most

helpful and enlightening if we had some reliable data on the net effect of such supervision and consultative services. For all we know, we might well be wasting a lot of good professional time and energy that could be better spent otherwise.

(5) *Prevention*

Beyond the early recognition and treatment of illness, not much is really known about the prevention of mental and emotional disorders. This is an area that needs vigorous study, and I will have more to say about it later.

(4) *Improvement of existing and procurement of additional facilities*

No community has adequate facilities to meet even the known psychiatric needs. Opportunities to participate in training, to coordinate services and facilities, and to catalyze action are numerous.

(5) *Improvement of the social climate which makes for "health"*

To change a society to produce responsible, free-thinking, independent, civic-minded citizens is a most worthy, but enormous, undertaking. We are still lacking the theory and techniques to guide us.

It should be clear that the opportunities to function as a social agent in the community are varied and vast, but I believe it is impossible for any one center to become active and proficient in all areas. With this temptation constantly beckoning on the one hand, and with our need to justify our existence, inability to cope with treatment demands, and long waiting lists on the other hand, it is not too difficult to understand why we might easily drift into a kaleidoscopic community program. The only program that is justifiable is one in which the center has a reasonable amount of control

over its destiny. This means it will have to define its goals, establish a priority system on its activities, and critically evaluate its work periodically. The center will need time to experiment with different ideas, sound out the community, and get valuable experiences. Boards should appreciate this and be encouraging and supportive. The staff should gradually settle for a limited number of objectives instead of trying to cover the entire waterfront. With the professional talent present in the three disciplines representing medicine, social work, and psychology, a considerable amount of knowledge, technique, and experience is available to the community, but we have the job of making it useful and translating it into action.

Perhaps by highlighting some of our own activities in the Columbus community, I shall be able to focus on some of the problems we ran into, how we coped with them, and the results we obtained. When the center opened its doors in May, 1955, it found itself in the midst of a large, psychiatrically-poor community. Immediate demands were made to provide psychiatric services for the indigent. It was most difficult for the agencies to understand our policies making it clear that our facility was not to be used exclusively for treatment, nor was it to be used primarily for the indigent. Our aim was to make available competent outpatient diagnostic and treatment services to an even larger group of people representing broad socio-economic needs (emphasizing those of moderate means) and also to provide for long-range community and research programs.

Our refusal to assume sole responsibility to provide such psychiatric services made us a target for a good deal of resentment and misunderstanding. We believed that services for the indigent and low income individuals should be a responsibility of the

total community and should be tax supported. We thought that by accepting all such requests ourselves we would soon be flooded with emergency, hopeless, or difficult cases and would relieve the community agencies and groups of pressure for establishing a realistic public program for mental health services. Also, had we responded to the above clamors, we would have been forced to refuse services to a larger number of relatively self-supporting persons for whom there were no services in the entire area. Since it was necessary to refuse direct services for agency clients, we offered consultation and supervision services to their staffs to help them deal more effectively with their clients having emotional problems. We tried to avoid pauperizing the agencies by insisting indirectly they could handle more problems with some assistance. While the offer was received with apparent interest, actual consultation services were used by only one agency over a two and one-half year period. We failed in this area and decided to give it up as part of our community activity. Nevertheless, our stand did keep alive the need for additional psychiatric facilities, and later we played a vital role in helping to bring this about.

By this time we had had the opportunity to become familiar with the community, so we made an appraisal of the situation and decided to work toward the unification and coordination of the agencies (8). Previously (in 1953) Community Research Associates spent \$25,000 of the community's money in a careful, well-documented study of the agencies. Their findings pointed up some serious weaknesses and deficiencies. Remedial steps were suggested, but no realistic progress had been made in three years. At this point, with the encouragement of our board, we took the initiative and held two conferences which led to the establishment of a Community Guidance Council. It is

our belief that our ability to get such a group started was based largely upon our own unique situation in the community, including our lack of official connections, the flexibility of our program which permitted us to allocate large amounts of staff time to this work, and the support and influence of our board of directors. During the next 18 months, we pursued a stormy course but managed to do some excellent work. Pressure for a psychiatric clinic continued, and we suggested that rather than make vague demands for such a clinic, which had failed in the past, we conduct a systematic survey of known existing needs for psychiatric and psychological services. Such a survey was carried out over an 11-month period with the cooperation of major community agencies, and a report was prepared. The center's staff gave hundreds of hours of time in making the survey and preparing the report. Its recommendations were unanimously adopted by the council, accepted by the newly reorganized mental health association for study, and were given community-wide publicity in the form of a series of newspaper feature articles. In this way, community pressure for a clinic was mobilized and intensified. In addition, the council sponsored a seminar on emotional and social problems, adopted a common referral form for the agencies, and started a pilot study on the multi-problem family. Lastly, a project on the unification of all community planning groups was undertaken which eventually led to the establishment in April, 1958, of the Community Services Association. The aim of this association is to provide central leadership and interpretation and direction for studying, planning, and action on all the community's unmet needs. Four separate, uncoordinated planning groups were abolished. Many people participated and made this possible, but the center's staff gave

generously of its time and professional talents.

In other community activities we have participated in innumerable talks, conferences, panels, seminars, etc., but we have now relegated this function to a position of lesser import. Instead, we are concentrating our efforts on sponsoring at least one professional conference each year. In this connection, we sponsored two religious-psychiatric conferences out of which an embryonic training program in pastoral counseling has developed. In 1958 we assumed initiative in a different direction when we sponsored the first psychiatric symposium of its kind for psychiatrists, psychiatric social workers, and clinical psychologists in this region. The response was so warm and enthusiastic that we are planning to continue this as an annual event. Approximately two years ago, we called a meeting of the social workers in the community, and since then the group has been meeting on a regular monthly basis. About a year ago we opened a new area when we initiated a conference attended by all the community's mental health professional personnel to determine what we could do to help each other and the community. Then we embarked on a new venture: (1) to develop a program of interest to the group, (2) to investigate how to better coordinate our resources, and (3) to study the possibility of combining our facilities to develop on a community level a postgraduate training course for the community mental health personnel of the future. I trust I have made it clear that I would see the mental health center as a well-trained, capable psychiatric unit which has clear-cut objectives, is sensitive to individual and social needs, and possesses the flexibility and mobility to seize the opportunities the community presents it, or to create them if necessary, to accomplish its missions.

While it is all but impossible to assess the direct or indirect effect the center has had on the community, the following developments have taken place: (1) A social worker was obtained for a short period by the juvenile court; (2) The local Public Health Department opened a child guidance clinic; (3) The county school system established a guidance center; (4) A new psychiatrist came into private practice; (5) A research project on mental retardation in the county began operation; (6) A 12-bed psychiatric wing was opened at the medical center; (7) The local mental health association experienced a rebirth, and (8) Four separate, uncoordinated planning groups were abolished, and a single, centralized, planning and action unit, the Community Services Association, was established. The community has acquired a total of 14 professional people in the field, where only a short time ago, there was one. We do not pretend to claim all or even a significant amount of credit for these specific developments, but we do believe we have stimulated the community in many ways and have contributed to increased interest and a changing attitude that have made such developments possible.

III RESEARCH PROGRAM

If we are to improve current methods or devise new ones for helping the mentally and emotionally ill, it is imperative to devote some time and energy to research. But how to do it and on what are constant companions. Every center can make a contribution to breaking through these barriers by attempting to engage in at least one project that is related to either its clinical or community program.

I believe I have given you two illustrations of what we have done in Columbus in this regard with reference to the problems of our intake methods and the difficulty of eliciting community support for a

psychiatric clinic without any realistic notion of the need for it. In one instance, the results of research efforts eventually led to improved clinical services and, in the other, to a much clearer definition of the extent of mental and emotional disorders and increased pressure in the community for a new facility. Currently, we are making a critical analysis of our case load.

All of us, I am sure, are interested in prevention, but there has been no approach to the prevention of major emotional problems or in the fostering of better mental health which parallels the successes being achieved with many physical illnesses. Such an approach is urgently needed in view of the magnitude of the problem and the inadequacy of our total existing resources to cope even with critical needs. Programs for preventing mental illness may be the ultimate answer, but at this stage of our knowledge, too little is known about what causes or prevents mental illness to permit effective planning or action. An approach in keeping with our level of knowledge is one aimed at reaching and appraising the mental health of non-psychiatric populations. Economic means of appraising the mental health of large numbers of individuals will also enable us to identify persons with problems before they become actual psychiatric patients. These means will make possible more efficient long-range planning for the use of existing psychiatric facilities and personnel and also the better utilization, with or without psychiatric consultation, of such professional persons as social workers, public health personnel, and physicians in detecting and relieving such problems.

What I have just described represents our major research interest which dates back to April, 1957, and was inspired by MacLeod's idea of a "Well-Being Clinic" (9). We raised the question if, in the light of our current

knowledge and techniques, it was possible to give any individual a "check-up" on his emotional condition just as it is possible for the physician to give a physical check-up, a dentist to give a dental check-up, etc. This project, on "Mental Health Evaluation of Nonpsychiatric Populations," has developed slowly but surely and now absorbs most of our research efforts. I have already indicated how the project has contributed to a refinement of our clinical diagnostic methods. We have completed, or are completing, mental health evaluations on 89 "normal" subjects. One ex-subject, an industrial leader, has invited us to use his entire organization as an experimental group. Several physicians are interested in, and one is using, our methods to evaluate patients.

Before I close, I should like to make a few remarks about the professional persons who are involved in all of this. To see a need for change is one thing and is relatively easy, but to change is something else again and most difficult. Being the humans we are, we naturally have feelings—sometimes very intense ones—that are intimately entwined in everything we do. To change is at times very painful, for it might involve real or misinterpreted changes in the concept we have of our professional role, status, and prestige and our personal selves (10). We, more so than any other group, should exhibit the kind of patience we have for others going through similar processes. May we have Divine Guidance to help us plot a course through these changing times. May God grant us the wisdom, the courage, and the strength to face these real issues with the maturity that springs from knowing how to "Love thy neighbor as thyself."

In conclusion, it would seem to me that if any mental health center would do these things, that is, develop a meaningful clin-

ical and community program with a related research program, and do them well, it would make a real positive contribution to the well-being of the individual and his community and advance our body of knowledge about man. The satisfactions from such efforts cannot help but be deep and rewarding!

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HOWARD E. FREEMAN

OZZIE G. SIMMONS

The use of the survey in mental illness research

The substantive contributions of social scientists in mental illness research often

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This paper was read at the 1959 meetings of the American Association for Public Opinion Research at Bolton Landing, N. Y. This research is being undertaken by the Community Health Project directed by Ozzie G. Simmons. The Project is sponsored by the Social Science program at the Harvard School of Public Health and is supported by a grant (M 1627) from the National Institute of Mental Health.

¹ For a recent evaluation of the substantive contributions of social scientists, see Clausen, John A., *Sociology and the Field of Mental Health* (New York: Russell Sage Foundation, 1956).

² For examples: Woodward, Julian, "Changing Ideas on Mental Health and Its Treatment," *American Sociological Review*, 16(August, 1951), 443-54; Hollingshead, August B., and Fredrick C. Redlich, *Social Class and Mental Illness* (New York: John Wiley and Sons, Inc., 1958).

³ Cf. Felix, R. H., and John A. Clausen, "The Role of Surveys in Advancing Knowledge in the Field of Mental Health," *Public Opinion Quarterly*, 17 (Spring, 1953), 61-70.

have been brought about by the application of research techniques not usually part of the repertory of clinical investigators.¹ Among the methodological innovations which have proved useful is the survey method (and the structured interview), particularly in assessing public attitudes toward mental illness and in epidemiological research.² For the most part, however, the survey has been employed in mental health research involving "normal" populations and not directly or exclusively in investigations of either disturbed persons or their close associates.³

The clinical researcher has not encouraged survey studies of mental patients or their families. By virtue of their traditions, training, and research investments, clinicians sometimes feel threatened by the potential application of the survey to "their" patients; the use of an approach so radically different from their own results in accusations of "sacrificing meaning for fact," "losing sight of the individual," and "fragmenting the whole or configuration in

order to secure discrete units that can be counted."⁴

These and similar issues, of course, are voiced about the use of survey techniques in other contexts and are acknowledged as limitations by survey researchers.⁵ Moreover, a number of formidable issues can be raised regarding the specific application of the survey method to the study of the mentally ill. These include:

1. The difficulties of gaining access to an informant population and of obtaining cooperation even when access has been secured;⁶
2. The dangers of upsetting the emotionally disturbed person or his family members;⁷ and
3. The problems of obtaining a field staff willing and able to undertake interviews with severely disturbed persons or with others in households where they reside and capable of coping with the range of problems they may encounter.⁸

In comparison with other social research methods—case study and participant observation—the survey is clearly less compatible with the orientations of psychiatrists, clinical psychologists, and social workers whose cooperation is essential, if only to gain access to populations appropriate for study. This was one of the considerations that led to the employment of the case study approach in the initial development of a program of systematic research on the community aspects of psychiatric rehabilitation. Although longitudinal studies of the post-hospital experience of a small number of patients and their associates continue as a major focus of the research program, in the past three years we have also completed two survey-type studies and are presently engaged in the field phase of a third:

1. An exploratory study of 59 former patients and their relatives;
2. An investigation of 182 female relatives of male patients who have succeeded in remaining in the community for at least one year after hospitalization; and
3. A panel study of 500 relatives of formerly hospitalized patients in which the first interview takes place a month after the patient is released, and the second, one year after his return to the community, or sooner if rehospitalization occurs.

This paper chronicles our experience in conducting these studies, with particular emphasis on our completed survey of 182 wives and mothers of male patients who remained in the community for over one year. The substantive findings of the first two studies have been reported in detail and will be reviewed here only to illustrate the usefulness of the survey approach in

⁴ Simmons, Ozzie G., and James A. Davis, "Interdisciplinary Collaboration in Mental Illness Research," *American Journal of Sociology*, 63(November, 1957), 297-303.

⁵ Cf. Hyman, Herbert H., *Survey Design and Analysis* (Glencoe, Illinois: The Free Press, 1955).

⁶ For example, in one follow-up study of mental patients in the Boston area, less than 50 per cent of the interviews were completed. Bockoven, J. S., A. R. Pandiscio, and H. R. Solomon, "Social Adjustment of Patients in the Community Three Years After Commitment to Boston Psychopathic Hospital," *Mental Hygiene*, 40(July, 1956), 353-74.

⁷ In fact, in at least one instance, mental health research directed not at patients or their families but at a total population resulted in undesirable consequences for the community at large. Cumming, John, and Elaine Cumming, "Mental Health Education in a Canadian Community," Benjamin D. Paul (ed.), *Health, Culture, and Community* (New York: Russell Sage Foundation, 1955), 43-70.

⁸ Cf. Felix and Clausen, *op. cit.*

mental illness research.⁹ In addition to describing the uses of the survey, we examine, in terms of such criteria as loss and no-response rates, the limitations when patients are used as informants and the greater potential yield when relatives are employed instead. Finally, decisions and actions taken which have relevance for promoting the feasibility of surveys are discussed.

USES OF SURVEY METHOD

In our experience, we have found the survey method useful in meeting three research needs:¹⁰ 1) providing parameters and descriptive data, 2) comparing characteristics

of mentally ill persons and their families with "normal" populations, and 3) documenting relationships between patients' posthospital performance and characteristics of family members and family settings.

1) *Providing parameters and descriptive data:* Our first survey, an exploratory study of a small number of former patients and their families, was primarily undertaken to provide parameters of a particular subpopulation from a local state hospital. We were asked to undertake this survey by another research group in the area who had completed a "clinical" study of patients and their families. Although this clinical team had gathered considerable data, they had failed to obtain systematically such basic information as the composition of the patient's household, ages and occupational histories of family members, use of community agencies by the family, rent, and income. The use of surveys to provide descriptive data results in the least resistance from the practitioner and is perhaps the most appropriate way of "selling" a study and gaining entree into mental illness research opportunities.

2) *Comparing mental patients with typical populations:* In our other research—longitudinal case studies of formerly hospitalized patients and their families—various facets of the social life of the families appeared quite unusual. For example, a number of the families were residually unstable, and, among those who had not recently moved, many were constantly seeking new living quarters. These mobility patterns were noteworthy, particularly because of research pointing to a relationship between residential mobility and mental illness.¹¹ In the survey of 182 families of formerly hospitalized patients, we attempted to ascertain whether or not the mobility of families could be tied to the mental illness. In order to do this, we replicated aspects of

⁹ Davis, James A., Howard E. Freeman, and Ozzie G. Simmons, "Rehospitalization and Performance Level among Former Mental Patients," *Social Problems*, 5(July, 1957), 37-44; Freeman, Howard E., and Ozzie G. Simmons, "Mental Patients in the Community: Family Settings and Performance Levels," *American Sociological Review*, 23(April, 1958), 147-54; Freeman, Howard E., and Ozzie G. Simmons, "Wives, Mothers, and the Posthospital Performance of Mental Patients," *Social Forces*, 37(December, 1958), 153-59; Freeman, Howard E., Ozzie G. Simmons, and Bernard J. Bergen, "Possessiveness as a Characteristic of Mothers of Schizophrenics," *Journal of Abnormal and Social Psychology*, 58(March, 1959), 271-78; Freeman, Howard E., and Ozzie G. Simmons, "Social Class and Posthospital Performance Levels," *American Sociological Review*, 24(June, 1959), 345-51; Freeman, Howard E., and Ozzie G. Simmons, "The Social Integration of Former Mental Patients," *International Journal of Social Psychiatry*, 4(Spring, 1959), 264-71; Simmons, Ozzie G. and Howard E. Freeman, "Familial Expectations and Posthospital Performance of Mental Patients," *Human Relations*, 12(August, 1959), 233-42. E., Ozzie G. Simmons, and Bernard J. Bergen, "Residential Mobility Inclinations among Families of Mental Patients," *Social Forces* (in press).

¹⁰ Felix, R. H., and John A. Clausen, *op. cit.*

¹¹ Tietze, Christopher, Paul Lemkau, and Marcia Cooper, "Personality, Disorder, and Spatial Mobility," *American Journal of Sociology*, 48(July, 1942), 19-39.

Rossi's study of the residential mobility inclinations and actual mobility of families in Philadelphia.¹²

Rossi found that both mobility and inclinations to move are the result of an incompatibility between the facilities offered the family in its present housing unit and its housing needs. He was able to predict inclinations to move in terms of such determinants as dissatisfaction with present housing arrangements. For example, one predictor of a family's inclination to move is whether they think there is enough closet space in the present dwelling. We found this to be a problem among families of former mental patients as well; whether it be a typical family in Philadelphia or a mental patient's family in Boston, one out of three households does not have enough closet space and is trying to do something about this. Indeed, most of Rossi's variables predict mobility inclinations among families of former mental patients more efficiently than they did in the original study.¹³ Findings such as this have warned us away from making "easy" interpretations of the behavior of families of mental patients as being "pathological and manifestations of maladjustment."¹⁴

3) *Identifying correlates of mental health:* Although the survey method has proved valuable to us for descriptive and comparative investigations, its most important use has been for testing hypotheses concerning correlates of mental health. In our research, we have documented a number of variables which are associated with the posthospital occupational and social performance of patients who succeed in remaining in the community.¹⁵ Without going into the qualifications, we would like to review briefly some of the findings. The relationships concern correlates of occupational and social performance levels among male pa-

tients who succeeded in remaining in the community for over a year:

- a) Patients with high performance levels were found in conjugal families and patients with low performance levels in parental families;¹⁶
- b) Low level patients reside with female relatives who are "atypical" (at least with respect to ideal stereotypes in our culture). These relatives tend to be authoritarian, anomic, frustrated, rigid, and withdrawn in comparison with relatives of high level patients;¹⁷
- c) Low level patients reside with families objectively rated lower class and who identify themselves as "laboring class;" high level patients live in fami-

¹² Rossi, Peter H., *Why Families Move*, (Glencoe, Illinois: The Free Press, 1955).

¹³ As another example, see Freeman, Howard E., Ozzie G. Simmons, and Bernard J. Bergen, "Possessiveness as a Characteristic of Mothers of Schizophrenics," *op. cit.*

¹⁴ Tietze, Christopher, Paul Lemkau, and Marcia Cooper, *op. cit.*

¹⁵ We urge caution, of course, in generalizing from our findings. The study group was drawn from a single metropolitan area and consists of patients selected in terms of age, diagnosis, and other characteristics. Some of our findings regarding family settings and posthospital occupational and social performance, however, have been confirmed by studies of Carstairs and associates in England. See Brown, G. W., G. M. Carstairs, and Gillian Topping, "Post-hospital Adjustment of Chronic Mental Patients," *The Lancet* (September, 1958), 685-89, and Brown, G. W., "Experiences of Discharged Chronic Schizophrenic Patients in Various Types of Living Group," *Milbank Memorial Fund Quarterly*, 37 (April, 1959), 105-31.

¹⁶ Freeman, Howard E., and Ozzie G. Simmons, "Mental Patients in the Community: Family Settings and Performance Levels," *op. cit.*

¹⁷ Freeman, Howard E., and Ozzie G. Simmons, "Wives, Mothers, and the Posthospital Performance of Mental Patients," *op. cit.*

lies rated objectively as middle class and who identify themselves as "middle class;"¹⁸ and

- d) Parental families with low level patients were found to have more adult males in their households (who can supplement the patient's performance) than families of patients with high performance levels.¹⁹

APPLICABILITY OF SURVEYS

Our research, like most substantive investigations, has had to forsake the luxury of systematic methodological evaluation. We have attempted, however, to appraise informally the data collection and analysis phases of our studies and to assess the research in terms of criteria such as refusal rate, no-response rate to individual items, and consistency of information between interview and other available data. In addition, we recorded interviewing problems and effects of the interviewing procedure on the informants.

1) *Refusal rate:* The results of our first survey, in which both relatives and patients were interviewed, were quite disappointing as to refusal rate. An attempt was made to interview 59 patients as well as a relative in each household. In less than half of the cases, however, was it possible to interview both patient and relative, and in 16 of the 59 cases, it was not possible to interview either one.

The refusal rate in the second survey was

considerably lower. Here we sought interviews only with relatives of patients. Interviews were attempted in 209 and completed in 182 cases (88 per cent). In addition, there were 16 cases in which we could not locate either patient or family. Even if these are included, the loss rate is still under 20 per cent, distinctly low for mental health research, and compares favorably with many market research studies. In our current survey, the loss rate is running below 10 per cent. We believe this lower rate is related to better use of the post office in locating informants, more careful checking of hospital records for addresses, and other considerations which will be discussed below.

2) *No-response rate:* In addition to the high refusal rate for patients, our first study resulted in an extremely high no-response rate to individual items among patients interviewed. Furthermore, it was difficult to "make sense" out of the responses of patients to scale items, suggesting the inapplicability of the survey method to patients. In all our research, however, the no-response rate for relatives has remained reasonably low, ranging between 10 and 15 per cent. We also find that the correlations of items and scales reported in other studies hold for their informants. For example, we found precisely the same magnitude of correlation between anomia and authoritarianism among relatives of patients as Srole did in his original research.²⁰

3) *Interviewing the assigned informant:* In all three studies, the interviews were conducted in the appropriate household, but in some cases, rather than the one assigned, another relative was interviewed. In these cases (about 5 per cent), however, the interviewer was able to justify this in terms of language difficulty, absence, or illness of the assigned informant.

4) *Consistency of data:* Although test-

¹⁸ Freeman, Howard E., and Ozzie G. Simmons, "Social Class and Posthospital Performance Levels," *op. cit.*

¹⁹ Simmons, Ozzie G., and Howard E. Freeman, "Familial Expectations and Posthospital Performance of Mental Patients," *op. cit.*

²⁰ Srole, Leo, "Social Integration and Certain Corollaries: An Exploratory Study," *American Sociological Review*, 21(December, 1956), 709-16.

retest reliability measures are not available, it was possible to compare the interview data on a number of background variables with information obtained from the hospital records of patients. In terms of these variables, the information obtained in interviews with relatives is consistent with that in the hospital records; ages of household members, for example, rarely varied by more than a year, and such items as birthplace of family members are remarkably consistent between both sources. There is, however, considerably less consistency between patients' responses and hospital record data, again pointing to caution in the use of patients as informants.

5) *Psychological effects*: The field phases of all our research have been conducted, to the best of our knowledge, without any serious psychological consequences for informants, former patients, or even interviewers. While it is necessary to add the qualifying phrase "to the best of our knowledge," the other work of the Project involves continual contact with the hospitals as well as with local social agencies, and it is likely that any serious consequences of the interviews would have come to our attention. We do have telephone calls from persons who are anxious, suspicious, and antagonistic, but we have found it possible to handle these problems in rather ordinary ways, eventually obtaining cooperation from most informants.²¹

In general, then, the evidence indicates the applicability of the survey method to relatives of mental patients but not to former patients themselves, at least not to those diagnosed as "psychotic."²² The refusal rate, the no-response rate to individual items, and the inconsistencies in responses encountered when patients were used as informants suggest that the survey approach is most applicable when other family members can be interviewed. The limitations

when patients are informants probably are related both to the psychological condition of some of the patients and to the anxiety and hostility about "the past" in others whose psychological state may be somewhat more stable.

DECISIONS AND ACTIONS TAKEN

For the most part, of course, the operations carried out during various phases of our studies are typical of, and required in, all survey-type investigations.²³ We feel, however, that certain decisions made and approaches taken expedited the research and merit comment.

1) *Planning and administration*: One of our major concerns in planning the surveys was with "public relations," i.e., developing relationships with hospital and other institutional personnel. Our need for access to records required an extensive program; we sought the collaboration of the state com-

²¹ The most extreme case was the gentleman who came to the office complaining and threatening to mobilize three veterans' organizations against the psychiatric profession.

²² Other recently completed questionnaire research also indicates the probability of successfully administering structured items to relatives of mental patients. See Freeman, R. V., and H. M. Grayson, "Maternal Attitudes in Schizophrenia," *Journal of Abnormal and Social Psychology*, 50 (January, 1955), 45-53.

²³ We might note that surveying families of formerly hospitalized mental patients has, surprisingly enough, some distinct advantages. Certain parameters are available, and the size and many of the characteristics of the study group can be reasonably estimated. Also, having access to hospital records permits, as we have described, an evaluation between the results of our interview, in terms of consistency, with hospital record data on a number of social variables. In addition, we used information from hospital records to evaluate the "honesty" of our interviewers. Cf. Hill, Reuben, *Families Under Stress*, (New York: Harper and Brothers, 1959).

missioner's office and the staffs of 13 mental hospitals.

We first secured the cooperation of the Commissioner of Mental Health and his associates, which was readily provided. Then the "full treatment" given each hospital began with a letter from us to the hospital superintendent, backed up by a letter from the commissioner. Next, we visited either the superintendent or his clinical director and, finally, in most cases, explained the projected study at a meeting of the professional staff. As a consequence of these efforts, we received the necessary support when informants called hospital personnel questioning the legitimacy of the survey.

The importance of an adequate public relations program was brought out by an attempt on our part to "cut corners" in the case of the most distant hospital. This hospital, some 45 miles from the office, did not receive the "full treatment" since they agreed to cooperate after correspondence. At least one of our refusals resulted from this; an informant, after part of the interview, asked if she could continue it the next day because she had an appointment; our interviewer agreed, but when he returned, he was not admitted. She had called the hospital, and her son's physician told her he had never heard of the Community Health Project, and she should not answer any more questions.

We reached the decision early in the pre-field phase to employ psychiatric social workers or other clinically sophisticated persons as interviewers. Not only were their backgrounds and skills deemed appropriate for our interviewing needs, but the fact of their employment helped "sell" the study to hospital personnel. Also, it provided insurance against the raising of the issue that we had not taken every precaution in the event that an informant were to be-

come upset by the interview experience.

A by-product of the public relations program with the hospitals was the opportunities it provided for obtaining candidates for the part-time interviewer jobs. Before we interviewed each candidate we consulted either our staff psychiatrist or staff social worker. In almost all cases, we secured information on their capabilities and experience prior to the hiring interview in which we really sold the job instead of evaluating the applicant.

It also seemed advisable to notify informants in advance of the interview. A letter was sent describing the proposed visit; it explained that the information obtained would be useful in improving the post-hospital treatment of patients in the future. The letter specified, as an explanation of how we knew about the family member's illness, that the hospitals were collaborating with us, but it also assured informants that information would be kept confidential from hospital personnel as well as from others. Along with the letter, informants received a self-addressed postcard in case they cared to indicate a convenient time for the interview. About one-third of the cards were returned. Of course, even if we did not receive a card, an attempt was made to complete the interview.

These letters were sent ordinary mail, but the envelopes were stamped "*Postmaster: Do Not Forward, Return To Sender.*" Each one returned to us was sent out "certified mail" with a request for the new address. This procedure enabled us to locate families who had left forwarding addresses. In our current survey we are sending all letters "certified" and paying the fee for receiving the informant's current address. This appears to raise interest on the part of the post office in delivering the letters and to emphasize the importance of the survey to informants who do not

appear to find receipt of certified mail up-setting. It is necessary, however, to stamp the envelope "*Postmaster: If Not Delivered In Five Days, Return To Sender,*" since certain informants are extremely negligent about picking up even certified letters from the post office. Since we do know after they are returned if the address is correct, we then send the letter again via the regular mails.

The public relations program that is required will vary, of course, from study to study in mental health research as it does in all survey investigations, but it is likely to impede the researcher drastically if neglected. During the pre-field phase of our current study, we have continued the information program with hospital personnel and extended it to other community persons whose aid, advice, and assistance are required. For example, a number of the families included in the study group live in public housing projects. Sometimes it is difficult to locate an apartment because the names have been scratched off the directories by children in the neighborhood. Attempts to obtain the apartment number from tenants in the project are usually unsuccessful, since the interviewer is perceived as a bill collector or policeman. We then arranged to secure apartment numbers from the city housing authority, a procedure requiring several contacts, letters, and telephone calls to various city officials before such cooperation was forthcoming.

2) *Interviewer training:* As we have reported, our public relations program with the hospitals netted us a large group of psychiatrically trained persons from whom we selected our interviewers. In both the completed study of 182 cases and the study presently in the field, we conducted similar training programs. Three meetings were held with the entire interviewing staff (which in the new study is 26 persons), and

a fourth with either individuals or with three or four people at a time. At the first group meeting, the purpose of the study was explained. We have had to balance the problem of telling interviewers enough about our study to keep them motivated and interested without telling them so much that the study might be influenced by their biasing the results either for or against us. Our policy has been to offer a general and somewhat vague explanation of the study and never to point up specific hypotheses. On the other hand, we have always provided accurate information in response to direct questions. Since publications of the completed research are available to many of the interviewers, and indeed "required reading" for some of them by the hospitals in which they work, many of them have more knowledge of the study now in the field, which is in part a replication of the previous one, than we think is desirable.

At the first meeting, we also discussed such interviewing procedures as ways of contacting informants and establishing rapport. Since our field workers are persons with a considerable investment in interviewing techniques, these discussions were more of an exchange between professionals than didactic training sessions. Indeed, we modified certain of our views on the basis of these discussions; for example, we felt that telephone calls should not be attempted in contacting informants but that the interviewer should approach the person "cold."²⁴ The majority of the interviewers disagreed, and we decided to leave it to their discretion, at least during the pretest.

Since there were no refusals when telephone calls were used, we permitted telephone contacts throughout the study and found no differences in the refusal rate for

²⁴ Cf. Goode, William J., *After Divorce* (Glencoe, Illinois: The Free Press, 1956).

these cases as compared with those in which the initial contact was face to face. This is, of course, not to recommend the indiscriminate use of the telephone for arranging interviews, although it does save considerable time in call-backs for informants not at home. The probable reason our interviewing staff is successful with telephone contacts is that, being social workers who use this approach in their regular job activities, they have a well developed "telephone role." If interviewers without such experience were employed and telephone contacts were desirable, we would certainly want to utilize role-playing techniques before employing this procedure.

The second meeting was primarily for discussion of the pre-test interview schedule. Each interviewer was then assigned a case and conducted an interview. This procedure not only yielded us a number of pre-test interviews but gave an opportunity for each interviewer to practice with the schedule. When the pre-test interview was completed, an individual conference was held with each interviewer or with small groups of interviewers if they worked at the same agency or hospital. We not only considered specific interviewing problems but requested and received many excellent suggestions on question wording, question order, and ways of reducing anxiety of informants by modifying certain introduc-

tory stems.²⁵ At a third group meeting, the final interview schedule was discussed and administrative problems reviewed.

In discussing our studies with survey researchers, the use of social workers as interviewers has evoked considerable comment, particularly with respect to their willingness to interview with a structured schedule. We are convinced that it is the type of relationship developed with the field staff that determines whether they will accept this interviewing approach. It must be made clear to them that their role is one of interviewer and not one of research collaborator; and that although they are professional people, they are not in this case responsible for the research methodology. This view must be mentioned throughout the study, and one does find it necessary to take the drastic action of dropping interviewers who will not cooperate fully. Despite our "toughness," we have had a reasonably stable field staff. For example, in the new study, after four months of field work, we are still employing 23 of the 26 interviewers originally hired. We believe that this stability is due not only to the way in which we have defined and conducted our relationship with the interviewers but to the financial compensation we have offered as well. It is only realistic to state that, apart from any other considerations, good performance from interviewers can be expected only if fair remuneration is received. To that end, we have paid \$10.00 for each two-hour interview plus remuneration for travel time, mileage, and any time for conferences that may be required.

3) *Field work:* After the last interviewer meeting, we assigned each interviewer two cases. Completed interviews are replaced by mail as they are returned. Two weeks are allowed for completion of an interview. In our current study, the interview must be

²⁵ One of the major problems raised was the responsibility of the interviewer to informants who requested advice and assistance. In our completed study, since we did not intend to follow up informants, we indicated that while no direct assistance should be offered, we had no objection to the interviewer's referring the person to an appropriate agency. We estimate referrals occurred in between 15 to 20 per cent of the cases. In our present study, however, such a procedure would do violence to our two-stage design. Therefore, we have insisted that no referrals or other assistance be given during the interview.

completed as soon as possible after the patient has returned to his family setting; thus, deadlines are held to inflexibly with few defections.

The refusal rate in our current survey, as noted, runs under 10 per cent. In about half the cases where we are initially met with refusal, the interview is ultimately completed. A number of these cases are obtained by assigning the informant to another interviewer. For example, in some Italian families, male interviewers are not accepted by married female informants. Cultural variations are considered in initial assignment of cases, but the practical problems of matching interviewers to informants limit this procedure.²⁶

As a last resort, we have sought the hospital's aid in obtaining an interview. In some cases, a letter from the hospital superintendent has allayed an informant's distrust or reluctance, while in others, a hospital staff member has helped us through a telephone conversation with the informant. We are aware of the biases that may be created by such pressure, but we have adopted the view that an interview secured in this way is better than none at all.²⁷

The field phase in both our large scale ventures has developed into a routinized situation, wherein the major problem is the formidable clerical task of assigning and processing interviews. In the current study, many of these clerical operations have been simplified by using an I.B.M. system for listing and keeping track of interviews. At the time the case is assigned to an interviewer, we have an I.B.M. card punched with basic information including the names of the patient and the relative to be interviewed. As the interview is completed, we add this information to the card. Each week we list these locator cards by a variety of sorts: alphabetically, the interviewer assigned to the case, the status of

the interview, the hospital from which the case is drawn, and so on.

Although cases are assigned by mail, we have frequent personal conferences and telephone conversations with interviewers, for questions arise continually regarding interviews. Whenever conferences are necessary, or the interviewer has had to visit the informant a second time through no fault of his own, we have increased the remuneration for the interview. Likewise, a higher rate has been offered as an incentive to have another interviewer try refusals and to motivate interviewers to call back in cases where informants cannot be easily located. It is difficult to estimate the costs involved in our studies, since some staff members participate in other project research as well. The field work comes to about \$25.00 per case, and if case selection procedures, coding, and office processing are included, we estimate that each completed interview costs four times this amount.

CONCLUSION

Our experiences in the use of the survey indicate that this approach can be advantageously employed in mental illness research. The problems encountered and

²⁶ In our studies, we have been concerned only with native-born patients, which has reduced considerably the number of foreign-born informants, even though parents of patients may be immigrants. The language problem, nevertheless, has been a major factor in our refusal rate.

²⁷ The interviews in our studies last about two hours. We find one need not worry about the length of the interview. From the comments of our interviewers, it appears that if there is any strain, it is on the part of the interviewers not the informants. This impression confirms the observation that respondents rarely show any strain or desire to terminate an interview even if it lasts for hours. Gross, Neal, and Ward S. Mason, "Some Methodological Problems of Eight-Hour Interviews," *American Journal of Sociology*, 59(1953), 197-204.

the limitations imposed are no greater than in most types of survey research. On the basis of our experience, we conclude that the success of surveys in this field is primarily dependent upon the systematic application of sound principles of survey research.²⁸ There are, however, special considerations that the researcher will do well to take into account. For example,

²⁸ Cf. Caplow, Theodore, "The Dynamics of Information Interviewing," *American Journal of Sociology*, 62 (September, 1956), 165-71.

²⁹ This is, of course, at variance with the view presented in Luszki, Margaret B., *Interdisciplinary Team Research: Methods and Problems* (New York: New York University Press, 1958).

we are convinced that our decision to use social workers was fortunate, and we would now be somewhat reluctant to undertake a study employing interviewers without social work backgrounds. On the other hand, our experience suggests that perhaps the social scientist has oversold himself about the special nature of mental illness research and the inapplicability of much of his methodology.²⁹

The survey approach has its limitations in mental illness research as in whatever field it is applied, but judicious application yields substantive findings that constitute a much-needed increment to systematic knowledge in this field.

Some orienting concepts for an effective mental health movement

Every organization which aspires to serve its community successfully must periodically pause to redefine the goals it has set, to take stock of its achievements, shortcomings, and resources, to re-infuse its sense of dedication, to sharpen its tools of services, and to reaffirm or modify the direction in which it proposes to travel.

With the burgeoning progress of the National Association for Mental Health, the need for such periodic stock-taking becomes particularly compelling. True, the formal occasion for evaluation customarily takes place at the annual meeting. The 1959 Annual Report of the NAMH bears eloquent testimony to the marked progress already achieved. In addition, reappraisal sessions by state and county affiliates undoubtedly result in constantly improved work.

What, then, is the specific focus of this paper? It is the writer's hope that the observations of a lay participant at a county

level may add a somewhat different perspective to the customary critiques.

In the hurly-burly of the day-to-day work—administering an office, planning a fund campaign, and responding to specific community needs—there is sometimes a tendency to lose sight of the trees for the forest. It requires an authoritative statement like the following to stop us in our tracks and force upon us an urgent reexamination of the fundamental socio-philosophic premises of our work:

"Tens of thousands of mentally ill patients in our nation today are receiving disgracefully inadequate care and treatment."

... "The resources we are devoting to mental illness today falls dreadfully short

Mr. Blumberg, a member of the New York City advertising firm, Blumberg & Clarich, Inc., is vice-president of the Bronx County Society for Mental Health and a vice president of the New York State Association for Mental Health.

of meeting the problem. We have not yet mounted an effective attack on mental illness in this country"—from a statement by Arthur S. Flemming, Secretary of Health, Education and Welfare at a press conference on April 20, 1959.

In the face of such a devastating judgment of need, we in the citizens' mental health movement had better ask ourselves some searching questions: Just where in the total constellation of forces, both public and private, does a citizens' mental health movement fit? What are its potentialities and its limitations in dealing with the massive and protean problems of mental illness?

More specifically, what constitutes a proper balance of effort in terms of staff commitment, use of financial resources and program planning between the work of the NAMH and its state and county affiliates in their capacity as a direct-supplier-of-needs, and their concurrent role as a community conscience, a catalyst, a prod, seeking to extract urgently needed funds from reluctant government authorities?

This is no abstract problem. As a matter of fact, the resolution of this basic problem of goal orientation confronts staff and lay boards at every turn. For example, to what extent is an association affiliate justified in using its all-too-meager resources to make direct research grants to public or private agencies? When is it justified in starting or helping to finance a mental health clinic or other pilot project, or to provide a professionally staffed referral service at headquarters? Alternatively, in what situations should it consider itself obligated to generate community pressure, by means of delegations, public pronouncements or direct lobbying on government agencies in the quest for adequate appropriations or legislative improvements?

If we are to judge by the documented

specifications of needs appearing in the 1959 NAMH bulletin, *What Are the Facts About Mental Illness?* we are constrained to apply a yardstick heavily weighted in the direction of the latter approach. Clearly, unmet needs are so vast that only a government-financed program of research, care, treatment, and rehabilitation can hope to make any appreciable dent in the situation.

This fact places upon a voluntary citizens' mental health movement the responsibility for shifting its main emphasis from what it does *directly* in providing funds or services to what it gets *governmental* units to do in the many-faceted attack on mental illness. This is not to minimize the indispensable role which such a citizens' movement must play in the sphere of public education and information. Certainly it is our unique task to provide the public with the essential facts and to develop sound attitudes with regard to the problem of mental illness. Additionally, it is our responsibility to foster community acceptance of modern concepts of treatment, care, and rehabilitation and to quicken the public conscience to the crying need for humane treatment of the mentally ill.

When we attempt to relate mental health needs to a rational concept of national security and welfare, or when we seek to determine the appropriate relative supportive roles of private initiative and governmental responsibility in this area, the following supposition might serve to clarify the emphasis I wish to convey. If we were told, for instance, that a hypothetical enemy proposed to blanket the United States with a nerve gas which would mentally debilitate 17,000,000 Americans, we would without question consider this an emergency of the very highest order. An all-out mobilization would be declared. Fantastic sums of money would be instantly appropriated to

ward off this devastating blow or, if the blow had already fallen, to repair the damage. No consideration of financial stringency, of inflationary pressures, or of mounting debt would be permitted to stand in the way of timely preventive or curative action.

Does it not logically follow that the interests of national security require us to assign a top order of priority to the expenditure of public revenue at least remotely commensurate with the fact that *we do have* 17,000,000 Americans categorized in varying degree as mentally disturbed or ill. The writer is well aware of the alleged stringency of available public funds at all levels, city, state, and federal. Yet, in a democracy, the people must ultimately be the judge of whether education, public health, housing, and mental health are receiving their just share of the community's total resources.

The foregoing comments are not intended to imply an inherent dichotomy of interests in the work of a citizens' mental health movement. Rather, they are designed to provide the basis for a rationale in determining proper limits of responsibilities between the private and public sectors of the forces arrayed in the battle for mental health.

SOME PRACTICAL FACTORS IN A COUNTY SOCIETY'S WORK

While the socio-philosophic concepts herein discussed are central to the formulation of broad policies as well as specific decisions in our work, there are other facets of a citizens' mental health movement which merit consideration. The writer's limited experience at a county level in a large metropolitan center (New York City) leads him to a number of tentative observations. These observations are not offered in any censorious sense, but as impressions based

on conversations with a number of staff and non-staff persons in a number of local affiliates, as well as participation in board work at a county and state level over a period of two years. To the extent that they bear any stamp of validity, their consideration may lead to a sharpening of our tools of work.

- 1) There is a *lack of specificity* in much which passes for educational work in the community.

All too often our educational efforts appear to be diffuse in nature, inadequately thought out in content and purpose, and undirected so far as their impact on target or leadership groups are concerned.

In planning our educational work we simply do not sufficiently spell out the specific end-goals, facts, motivations, and principles which we are seeking to impart.

It is a reasonable assumption that this, in turn, is a consequence of a certain fuzziness in our own thinking as to exactly what values and principles are subsumed in the concept of "mental health."

- 2) Adventitious factors too often determine the *programmatic work* of our local groups. We are not sufficiently and continuously at grips with the hard-rock realities of our work; we do not always closely relate our work to the ultimate "commodity," the human being in distress.

There must be, consequently, more specific planning of programmatic work for a specific period of time. This lack of specifically stated, time-scheduled goals is evi-

dent at all levels, county, state, and national.

If this statement is substantially true, how can we reasonably expect to mobilize the total resources of a volunteer citizens' movement into the most effective channels? A sound mental health program should, in the writer's opinion, be:

- a) Adequately *publicized* within and outside the association.
- b) Adequately *coordinated* so that all units at all levels can cooperate to achieve common goals—particularly in matters involving federal, state or local budgetary and legislative improvements.
- c) *Specific* in value, *limited* in scope, *achievable*, and related to the known needs of our various communities.

Here it may be added that a detailed acquaintance with one's own community's needs and resources is a *sine qua non* for effective work. Such knowledge which does exist is all too often concentrated within staff and is not made the common property of lay boards.

- d) Formulated in a definite *order of priority* so that staff, committee, and board workers can be guided in their allocation of time and so that *primary* goals receive *primary* attention.

While it is true that the local associations must give due weight to local needs, sight must never be lost of some basic mental health goals which transcend local geographical boundaries. The following

quotation will help us keep our feet on the ground:

"Our most urgent concern is for the hundreds of thousands of people who are wasting away in mental hospitals, unable to get the attention, care, and treatment they need."

"Progress in the fight against mental illness must be measured in these ultimate terms: How many people improve and recover after treatment? How many cases of mental illness can be prevented?" (From the 1958 Annual Report of the NAMH)

- e) Adequately spelled out in terms of an effective program of *action*. All too often, useful surveys are made and plans developed, only to be left to moulder in the file of good intentions.
- 3) Local research grants are sometimes given without relating the grant to any overall view of a society's total budget and resources, to proper professional screening, or to coordination with research grant needs on a larger geographic basis. Grants are sometimes approved as a "public relations" gesture to show the public "what we are doing" with their funds and to justify our existence to state supervisory agencies.
- Sight should never be lost of the fact that the only justification for solicitation of public funds rests with the practical programmatic work of a society.
- 4) The raising and disbursing of funds absorbs a disproportionate amount of staff and board time in comparison to time and effort expended in specific, constructive programmatic work.
 - 5) There are too many months of relative inactivity (so far as committee,

board, or programmatic work is concerned) during the year. Mental health needs do not take a vacation from June through September, nor in December.

- 6) Board agendas are too often loaded with routine, peripheral and inner-administrative problems to the virtual exclusion of matters of primary concern.
- 7) State and national associations do not call upon local affiliates to lend support to specific objectives which transcend local interest.

While recognizing the enormously complex financial organizational problems which our national and state associations have to grapple with, it is nevertheless true that their *prime* responsibility lies in the area of co-ordination and program leadership in their respective fields of jurisdiction.

- 8) Fund-raising itself is becoming an increasingly serious problem and must be viewed in the context of multi-fund pressures upon an increasingly resentful public. The present chaotic conditions cannot but seriously impair our effectiveness as a citizens' mental health movement. A serious, realistic tackling of this problem, despite its admitted intricacy, cannot be postponed for long.

- 9) County societies in a large metropolitan area must learn to discard provincial approaches and must begin to develop an effective coordinating mechanism on fiscal, organizational, and programmatic levels. Such co-ordination is simply indispensable in dealing with city-wide needs. Staff predilections or narrow concerns which, in any degree, conflict with the effectuation of sound overall policies, must not be permitted to stand

in the way of necessary coordination. The merits, and only the merits, must be the determinant in the solution of inter-county or county-state problems.

- 10) The whole area of fiscal responsibility, definition of income for purposes of allocation as between counties, (especially in metropolitan areas) state and national society to permit maximum efficiency at all levels is a serious problem requiring the most immediate and painstaking attention in order to arrive at a dispassionately intelligent solution.

- 11) While professionally-serviced headquarters' referral work is an essential part of a local society's work, there appears to be an overemphasis on this aspect of a society's total programming.

- 12) There is also a tendency, natural to lay boards, to equate all types of treatment methods and facilities as equally efficacious.

It is not here suggested that the society attempt to pre-empt the area of professional judgment as between the various schools of therapy, modes of treatment, facilities, etc.

Nevertheless, it cannot remain indifferent to the advance of modern scientific technology and validated concepts in the field of treatment. It must, with competent professional advice, evaluate the therapeutic contentions of psychoanalytic schools, of psychopharmacological or other psychotherapeutic approaches in its effort to stimulate the use of the most effective treatment possibilities for the mentally ill.

Reliance, in the main, on pervasive psychoanalytic approaches and resist-

ance to the advancing trend of empirically validated physiotherapeutic techniques, where indicated, can only serve to retard progress and improvement for tens of thousands of mentally ill persons.

- 13) Once a psychiatric facility is established, there is a tendency to assume that all is well. The need is presumably met. Such a satisfying conclusion, of course, is not always warranted. Adequacy of professional staff, both in numbers and quality, continuity of the doctor-patient relationship, as well as the technical and philosophic approach to treatment

procedures are all important elements in determining whether and how quickly a mentally ill person is helped.

CONCLUSION

The above observations and criticisms are not offered as typical or representative of any single county, society, or group of societies. Enormous improvement in skills and application is constantly in evidence. What is suggested is the need for an ever-critical and cautionary view of our work. The end is what counts, and the end product of our labors is a happier, healthier community.

Aftercare services for the mental hospital patient

A survey of 10 state mental hospitals in Pennsylvania

New methods in the care and treatment of the mentally ill in the United States, together with the widespread use of chemotherapy, have resulted in a drop of 13,000 in the number of patients in state mental hospitals today, compared to three years ago. Pennsylvania's state mental hospital population has decreased about 2,000 in the same period. These decreases have reversed the steady upward trend which prevailed for more than a generation.

However, more and more patients are being admitted to mental hospitals. Short-term treatment is getting many of them back home, and drugs are helping to keep many from returning to the hospital. So far, re-admission rates have not begun to climb. How long this progress can be maintained in the face of a rapidly growing national population will depend not only on the drugs but on the amount and quality of aftercare services developed by the hospitals and on the response of the community in helping the discharged pa-

tient make a satisfactory psychiatric, social, and vocational readjustment. Failure in either of these areas may mean a return to increasing populations in the hospitals.

Dr. Saul H. Fisher, in his paper, "The Recovered Patient Returns to the Community,"¹ warns:

"The decision for (hospital) discharge is not only a medical decision; it is a social one as well, just as the decision for hospitalization is based on social as well as medical reasons. . . . The patient is not 'cured,' as a rule, and he still may have symptoms. . . . Patients with tuberculosis may be 'arrested' but not cured. . . . So it is with psychiatric patients . . . unless condi-

Mr. Rosner was formerly Eastern Pennsylvania area director for Pennsylvania Mental Health, Inc., Philadelphia, Pa. He is now executive director of the Maryland Association for Mental Health, Baltimore, Md. Mr. Rosner began this study while a staff member of PMH, Inc. The analysis and opinions expressed are his own.

¹ *Mental Hygiene*, 42(October, 1958), 463-73.

tions after discharge are favorable, a relapse may occur, and the patient will be re-admitted to the hospital. About 30 per cent experience this the first year after discharge."

Dr. Fisher calls for an overall rehabilitation program which ensures the psychosocial and vocational rehabilitation of the mental patient. He notes:

"Rehabilitation must begin in the hospital, from the very point of admission. . . . Much has been learned in recent years, and excellent programs have been instituted in several hospitals." After reviewing these programs, he says that "the idea is to treat the patient as a totality, not as a series of parts, and only a truly integrated program can achieve this. This would require close coordination between the hospital, the rehabilitation center, and the community, and this can be achieved only with the full cooperation of all governmental, community, and private agencies."

Dr. Fisher's position is corroborated by Dr. Robert C. Hunt, Dr. George S. Stevenson and Dr. T. J. Boag (see bibliography). The most comprehensive encyclopedia of aftercare services for mental patients is contained in the publication "After Care Services for the Mentally Ill—A World Picture," by Lee T. Muth, Chief, Social Work Service, Veterans Administration Hospital, Huntington, West Virginia (published by the Mental Health Education Unit of Smith, Kline and French Laboratories, Philadelphia, Pa.)

In April, 1957, Pennsylvania Mental Health and Philadelphia Fountain House co-sponsored a conference concerned with the coordination of community resources in psychiatric aftercare. The conference was made up of individuals from the various psychiatric professions who had pioneered in the field. They came from different parts of the United States and from

Canada. Papers describing various projects in aftercare were presented and discussed.

One trend noted at this conference was, to quote the report of the proceedings, "the crumbling of the wall which for so long has divided hospital from community." It noted that "the hospital is only one phase of the treatment process. The community must carry part of the program with the family—or even with the patient himself. . . . It follows that the community and the hospital must work together."

The conference was in agreement that aftercare services could be rendered by community agencies and personnel including "the public health nurse, the general practitioner, the minister, service agency personnel, and other competent persons. . . ." Cooperation between the hospital and the community was stressed as the essential factor.

The hospital knows that often patients considered psychiatrically ready to go home face the risk of not making a satisfactory adjustment to family and community life. Many would have to go back to families not able or willing to take them back; this emphasizes the need for foster homes (or possibly rooms at the "Y" and elsewhere) and social centers (Fountain House) which could help them make an adequate social adjustment. Other patients may need a job more than anything else in order to make an adequate adjustment on leaving the hospital. Saul H. Fisher, in *Mental Hygiene* (October, 1958) notes that "work is valuable not only as a preventive for deterioration but as a vehicle for social rehabilitation." Boag makes a similar point in his paper "Rehabilitation in Mental Health" (Pennsylvania Mental Health, Inc., publication). Both Doctors Fisher and Boag favor foster homes and social clubs as well.

Halfway houses help the hospital staff

prepare the patient for normal family living, for independence, and for some work experience.

A "Big Brother" role is suggested by Dr. Boag, who refers to it as a "Special Volunteer Program;" he says it "is something like a 'big brother' program. For patients who we feel need a good deal of support which they are not able to get from their families, or where they have no family, we have a volunteer who is willing to try to fill this gap. To see the patient regularly, to provide support, friendship and companionship. . . ."

Mental health associations have sought to contribute to the task of promoting aftercare assistance to mental patients so that they can make satisfactory psychiatric, social, and vocational readjustments. However, in order that we might know the size and nature of the problem, we undertook a study of aftercare services and the role played by Pennsylvania's state mental hospitals in such services. We did not know how many patients were being furloughed or placed on extended home visits or what happened to them prior to their final discharge by the hospital. We did not know what contact the hospital staff had with these furloughed patients, what the nature of the contact was, and if there was a serious gap between what the staff did or was willing to do and what the furloughed patient needed and should have to make a satisfactory adjustment to his family and community.

These were some of the questions that prompted a survey of 10 of our 16 state mental hospitals (excluding the hospital for the criminally insane which presents unique problems). For geographical reasons, the six hospitals in the western part of the state were not visited. The survey was conducted during February, 1959. Meetings were held with the hospital super-

intendent and/or the director of social service, clinical director, or other personnel the superintendent felt should participate.

In the course of the survey, many differing attitudes were expressed by the hospital personnel about the need or wisdom for various kinds of aftercare services such as foster homes, halfway houses, out-patient clinics, social clubs, liaison with other social agencies, etc. One superintendent questioned the wisdom of any aftercare contact once the patient left the hospital. These viewpoints are incorporated into this survey report.

THE NATURE OF AFTERCARE SERVICES

Each hospital carries on its rolls those patients actually within its walls and those who have gone home on trial visits (called furlough or probation in some hospitals) of an extended nature. While on these home visits the patient can have his case reviewed by the medical staff and, if the staff considers him well enough, he may be permanently discharged; at this time his name is removed from the rolls, and the hospital no longer has any legal responsibility for him. Patients may be discharged any time during the first three years after they leave the hospital, but discharge becomes mandatory after the three years are up, unless the patient returns to the hospital for as long as 24 hours prior to that time. Some patients do this in order to maintain contact with the hospital or to make formal recommitment at a later time unnecessary.

While getting ready for furlough or extended home visit, and after leaving the hospital, the patient may have the following services:

1. Help in preparing his family for his return home. This can be given by either medical or social service staff.

2. Help in finding other suitable living arrangements if the staff feels he should not return home, or if there is no home to which he can return. Such arrangements may mean a foster home in the community, a room in a rooming house, YMCA, religious mission, etc. Or he may need to be placed in a county home or institution for the aged.

3. The hospital out-patient clinic where the patient is seen periodically to ascertain his psychiatric progress is often the means for checking on his progress in drug therapy and to prescribe another supply of drugs.

4. The hospital social service department may arrange to keep in touch with the patient by mail or by visits to his home or by contact at the out-patient clinic or special office run by social service in the nearest town to the patient. Social service, in turn, may advise the patient about contacting social agencies in his community (public assistance, public health or visiting nurses, family service, psychiatric clinic, etc.) and may help him make such contact although stopping short, usually, of an actual referral.

5. Rehabilitation services may be provided by the hospital and/or by the community. The hospital may work together with the Bureau of Vocational Rehabilitation to help find employment for the patient. It may establish living quarters on hospital grounds where the patient can learn once again to live in a family setting and work in the community during the day.

Special community services are being organized to help the patient in his social reintegration. These projects have been termed social clubs, friendship rooms,

Fountain Houses, Recovery Inc., etc. They try to help the patient resocialize with citizen volunteers in his home town who, in turn, seek to bridge the gap from the hospital back to the patient's old social contacts—his church, fraternal club, old friends, etc. Some communities outside of Pennsylvania have established residential centers for ex-mental patients and have helped them in making an economic and vocational as well as a social readjustment.

What this survey shows is that each hospital has engaged in some or all of the above functions, depending on its needs and resources, on the attitude of its superintendent and staff, and on community attitudes and resources. Some hospitals have sought out individuals and groups in the communities to assist their furloughed patients. Other hospitals have confined themselves to preparing the patient for his return home; once the patient leaves the hospital he is considered well enough to cope with his problems without further staff assistance. Some hospitals fall in between these two extremes.

THE SURVEY

The 10 hospitals surveyed have a total patient population of over 24,000. Approximately 6,800 additional patients were listed as on "extended leave status," on "furlough" or "probation," the terms being used interchangeably to refer to those patients who have not been legally discharged and are still carried on the books of the hospital. About 1,900 furloughed patients who have been out for varying periods up to three years returned to the hospital during 1958, a re-admission rate for this group of about 28 per cent.² Over 4,100 of these furloughed patients went on leave during the year 1958. Re-admission rates have to be considered in light of the purpose

² None of these figures are exact, ranging as they do from data taken from carefully kept records to "educated guesses" by the social service departments of the hospitals.

of the hospital staff in placing patients on furlough. Dr. T. J. Boag at Allan Memorial Institute of Psychiatry, where pioneering work has been done in modern treatment methods, has suggested that any time which a patient can spend at home in his community may be a positive achievement for him as well as for the hospital. A re-admission "always requires interpretation," he warns, "as it may often be quite a desirable feature in the treatment of a particular case."

Living Arrangements

Most of the patients on furlough are back with their own families, the specific hospital estimates varying from "over 95 per cent" to "about 99 per cent." Less than two per cent of the total were placed in foster or boarding homes. One hospital had placed 52 patients in a county home for the aged, and another hospital had placed about nine per cent of patients furloughed during 1958 in foster homes; this latter hospital has had an active foster home program since 1932. This program began by advertising in the local newspapers and by having staff members agree to open their homes to patients on leave. Another hospital has 20 patients in a nursing home.

In most cases, the Department of Public Assistance has provided funds for placing patients in nursing or boarding homes. But DPA has a legal restriction against paying for anyone who is still mentally ill, which often raises the question whether a patient furloughed from the mental hospital must still be considered mentally ill. One hospital has found that its county home for the aged will accept furloughed patients without DPA funds but only if the hospital, in turn, will take someone the county home feels needs to be committed.

This may benefit the patient being furloughed and possibly the newly-committed patient from the home, but the hospital feels it is not an ideal arrangement.

One hospital does not see a need for foster homes except in work situations where patients serve as domestics or farm laborers; it feels it handles these situations satisfactorily. Two hospitals feel they have more foster homes than they need and are doing an adequate job, mainly through social service, in finding suitable homes when needed. Two other hospitals find they are pressed from time to time to find suitable homes, but that they generally manage to find them, and that they would do a better job if they could employ more social workers; they do not favor help from citizens' groups like the mental health association since they feel it requires professional direction. The remaining five hospitals vary in the effort they put into foster home placement, ranging from those who do only an occasional placement from time to time, to one hospital which has an active placement program; but all five of these hospitals indicated that they see a need for help with this problem from a local mental health association. They are willing to explore this further with their county association.

Less than two per cent of all furloughed patients are living in single rooms, their own apartments, or in a "Y", Salvation Army residence, Rescue Mission, religious home, etc. Two of the hospitals reported as many as 10 per cent living in such quarters, usually individuals who had found jobs and were trying to be wholly or partly self-supporting.

Clinics

Only five hospitals have out-patient clinics where they see about 1,500 furloughed pa-

tients, usually on a monthly basis. They are generally on heavy drug therapy and are seen in order to check on the therapy and to provide the patient with another month's supply of free drugs. Four more hospitals said they want out-patient clinics and would establish them if they were given enough funds and staff. At present these latter four hospitals can give furloughed patients enough drugs for only a few days or a week and a prescription for their family physicians. The family physicians often fill such prescriptions for months or years without ever seeing the patients, according to one superintendent. One hospital which refers 99 per cent of its furloughed patients to their family doctors sends the doctor a summary of the patient's condition and invites the doctor to contact the hospital at any time about his patient. Some hospitals will refer patients to community psychiatric clinics. But in all planning with patients for help from clinics, DPA, or social agencies, the hospital limits itself to suggesting that the patient contact these agencies and will only make a specific appointment if the patient requests it.

The feeling on the part of some superintendents is that once the patient leaves the hospital and goes on furlough he should assume responsibility for his own care, including appointments with clinics or social agencies. There is a reluctance to hold on to the patient. As one superintendent put it, the mental hospital has no more "proprietary interest" in an ex-patient than a general hospital does in a former physically ill patient. The rationale is that most patients resent further contact from the hospital as interference and an attempt to keep them tied to the institution. More than 75 per cent of furloughed patients are thus not seen by clinic staff or social service, and only a fraction of them receive

follow-up questionnaires to determine how well they are adjusting to home life.

Social Service

Social Service sees about 1,800 furloughed patients during the year, mostly in conjunction with the out-patient clinics of the hospitals where the social worker prepares the case for the medical staff or does some supportive therapy with the patient or his family. The social worker arranges appointments by letter or phone. In one hospital, the social service department is responsible for manning a clinic in town; in another hospital, social service has an office in town. Supportive therapy is done in the former, under medical guidance.

Contacts with families of patients are very limited at present, only one hospital having organized a program for regular meetings; it holds monthly meetings in cooperation with a community civic group, and an average of 40 attend. Three other hospitals see relatives before patients are furloughed; three have occasional contacts with relatives who call or come in to see the ward physicians or social service. Three more hospitals would like to establish regular orientation sessions with relatives in order to develop insight and understanding and thus make the transition to home easier for the patient. Two of these hospitals used to hold such sessions and would do so again if they get funds and medical staff to make it possible.

Social service usually prepares a patient for furlough, although in some cases this may be perfunctory, the decision having already been taken by the medical staff. Only in three hospitals does the social worker send routine letters to the patient's family inquiring about his home and social adjustment. Such questionnaires may be very simple or very thorough in exploring the patient's condition, feelings, etc.; they

may be sent every three or six months or just on his annual date of furlough. They are evaluated and prove helpful in deciding if the patient should be discharged before his three years' probation are up. In some cases they might indicate a need to have the patient return to the hospital.

The other hospitals send letters to a few patients who may have special problems. In six of the hospitals, home visits are made where the patient becomes a problem, but none have a regular policy of home visits. Two hospitals used to visit the homes of all furloughed patients but gave this up as too time-consuming and because they felt very little good was accomplished. Except for the 1,800 seen in out-patient clinics and town offices or by social service, the hospital staff has almost no contact with those on furlough. Some patients may call or write or drop in to see their ward physician or social service worker, usually on visiting days, but no systematic program for follow-up has been instituted.

Two hospitals indicated that with more social service and medical staff they would be doing more home visiting or other kinds of follow-up work with patients on furlough. The social workers in all the hospitals have good liaison with the vocational rehabilitation counselor from the state Bureau of Rehabilitation. Two hospitals register selected patients with their social service exchanges and are, in turn, notified by the exchange if a furlough patient contacts a social agency. Liaison with social agencies is spotty, depending on the social service director in each hospital. Some maintain liaison with most of the agencies, either directly or through the council of community services or in professional association with other social workers. Agencies which have proved most helpful have been DPA, of course, family service, child welfare or

children's aid, and community psychiatric clinics.

PHN and VNA

Contact with the public health nurse or visiting nurse association has also been spotty. Six hospitals reported having occasional cases visited by the PHN or VNA nurse, and one hospital had furloughed patients in one county it serves visited during the past year (about 25 patients were seen). At least one more hospital would like to have this kind of follow-up. The hospitals have not expressed much interest in developing this resource, although in at least one county the VNA has expressed keen interest in providing the service free to furloughed patients. One hospital superintendent said he would be willing to pay the VNA fees if his budget would allow it.

REHABILITATION

Social Clubs

A reluctance to "control" the patient once he leaves the hospital was reflected in the attitude of some hospital staffs toward social clubs for ex-patients. Two hospital superintendents and the clinic director in a third hospital were opposed to these clubs on the ground that the ex-mental patient should not fraternize with other ex-patients but should re-establish old social and community contacts such as his church, service club, etc. One superintendent felt that only "hypomanics" want such clubs. Two others who favor social clubs for some patients warned that normal social contacts were the most desirable and should be encouraged. However, seven hospitals approved of social clubs, some with reservations. Four hospitals have worked with such clubs as Fountain House in Philadelphia and Bethlehem and the Reading Friendship Club.

Vocational Rehabilitation

All of the hospitals find the work of the vocational rehabilitation counselors valuable but have reservations about the time and effort spent on individual cases. The counselors do a good job with the patients they select, the ones who indicate good work potential at skilled, white collar, or professional levels. But the great majority of furloughed patients can do only unskilled work in factories or on farms or work as domestics in homes; very little is done to locate jobs for them. Some hospitals place them on farms or as domestics in homes where they live in. But many superintendents fear that the patient will be exploited in such situations and have generally stopped placing anyone in jobs of this kind. They feel a need for suitable job placements of unskilled patients where they are also protected. This is one area where the hospitals would welcome help from mental health associations.

Halfway houses exist in conjunction with three hospitals (although they are not necessarily situated on hospital grounds) and are wanted in three more. One hospital says it tried a halfway house but gave it up because the staff decided that the patient was usually well enough to go home when he seemed well enough for a halfway house environment. Three other hospitals do not feel they could run a halfway house, because they are too isolated geographically and could not combine the family type living with work opportunities on the outside. The hospitals which have the houses indicate they are very pleased with them and consider them a definite bridge back into the community.

SUMMARY

In summary it must be noted that the hospital has almost no contact with about 75 per cent of its furloughed patients. The

other 25 per cent are seen in out-patient clinics or by social service and vocational rehabilitation counselors or are contacted by letter and sent questionnaires. The hospital may feel that many of these patients are well enough to be discharged but are carried on its books the entire three years as a precaution and to make it easier for the patient to be readmitted if he has a remission. Or it may be that the hospital staff feels the patient should not be checked on too closely since it would cause resentment or might make him too dependent on the hospital. In order to facilitate his psychiatric, social, and vocational readjustment the patient needs help in a variety of ways. Superintendents and social service directors differ in what they consider the best ways, but there is sentiment in favor of having mental health associations and other community groups assist in:

1. Locating foster homes where the hospital feels such a need exists;
2. Exploring and promoting arrangements with public health and VNA nurses for follow-up of furloughed patients;
3. Gaining public support for more funds so hospitals can institute or expand out-patient clinics which would provide treatment as well as drug therapy and where drugs would be provided free; the cost to the public would be a fraction of what is now spent to provide custodial treatment to patients who could be furloughed under such conditions;
4. Promoting job opportunities for unskilled patients, especially by approaching industry in each community along the lines followed by the San Francisco MHA;
5. Stimulating interest in and support for social clubs for ex-mental patients;

6. Helping hospitals establish and furnish halfway houses and assisting in work with these patients so that they can find employment and eventually become self-supporting; a "Big Brother" role was envisioned by some hospital staff members;
7. Extending a "Big Brother" role to include helping the furloughed patient become accepted by his family, neighbors, and old social contacts, including church and clubs;
8. Planning regular orientation meetings for relatives of patients where professional staff can help develop the insight and understanding that relatives need for patients who return from the mental hospital;
9. Developing public support and funds for psychiatric clinics in the community, beds in general hospitals, orientation for family physicians, and any other facilities which would help the furloughed patient make a satisfactory adjustment.

How far hospitals and communities are prepared to go in carrying out any of the above programs may depend more on attitudes than on resources or personnel. Dr. George S. Stevenson warned in 1950 (8) that the state mental hospital, because of its remoteness from the community, tends to adapt very slowly to newer demands. He noted that:

"Progress in the mental hospital has tended to come from influences only within itself and to refine more and more the intra-institutional services to its traditional patients. It belongs to and feels for no one community because it serves many communities. Its distance from its communities has even affected its work on its traditional patients. For example, it is half a century since we came to appreciate the value of

knowing the home setting of mental-hospital patients, of discharging the patient into a suitable environment, and of continued aftercare treatment (follow-up) in the community after discharge. These community responsibilities have been recognized as important to the patient in the same way as the services performed within the hospital. But these services are not today generally provided as a part of psychiatric service to a community, though they are an earlier step in the progressive growth of the hospital than service to non-hospital patients."

The hospitals and communities are beginning to work together in providing aftercare services for the ex-mental patient. The process will have to be speeded up if our patient population is to continue its downward trend.

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Professional schools and mental health

Every professional school operates with certain beliefs and assumptions about human nature and human behavior and also the relation of the individual to social order. For the most part, these assumptions are not recognized nor explicitly stated; nevertheless, they operate as preconceptions and assumptions to guide the training of students and later their professional work when they enter upon the practice of their profession.

Before discussing the various professional schools, it should be emphasized that sooner or later it will be necessary to set up more effective screening procedures to select, for exclusion, those individuals whose personality make-up and immaturity, despite their intellectual ability and skills, make them potentially dangerous to our society if they

are permitted to engage in professional practices.

In many professions today, warped, distorted, and immature personalities are inflicting damage upon others whom they are teaching, treating, advising, etc., in their professional work. It is, therefore, important to recognize an initial or threshold task of better selection of candidates for all professional schools and to screen out those who cannot be expected to be interested in personalities and those who are not psychologically fit to be entrusted with the great power and responsibilities of a professional worker.

Looking at the situation in American universities today, we see a variety of professional schools on the same campus, under the same auspices, training students with not only different, but often with conflicting beliefs about human nature and social order, sending them out to engage in pro-

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fessional practice, to add to our already confused and conflicting society by their divergent beliefs and expectations. We cannot expect to advance mental health or the goals of an orderly society while the trained graduates of most of our professional schools are either actively opposed to the basic concepts of mental health or are indifferent or unwilling to collaborate in the immense task of achieving better mental health and a healthy social order.

A concerted program to reorient professional and graduate schools is, therefore, urgently needed today. Such a program would attempt to enlist the interest and cooperation of each of the professional societies or associations, the professional schools through their recognized associations, and especially the few individuals in each profession who are aware of what is involved. The purpose of such a program would be to stimulate and encourage each professional group to undertake its own reorientations, by providing materials and consultations and conferences that each may need. The aim of such a program is to infuse all professions with the awareness, understanding, and applicability of mental health principles in their regular professional practice, not to divert them or to convert them to psychiatric or social work activities. Only as all the professions can and will participate, can we hope to attain the goals of mental health.

It would also be highly desirable if one university in which mental health has been recognized in at least one or two professional schools would undertake a systematic exploration of the possibility of developing a consistent and integrated program of similar instruction for all its professional students in undertaking dynamic conceptions of human nature and human behavior. This will not be simple, and it will require some years of discussion and conferences by

representatives of the different professional schools to clarify their thinking and to work out such a common core of orientation and its adaptation to the needs of each professional school.

No more important task in professional education could be undertaken today than such an exploration. The university which undertakes this will be making a great contribution not only to professional education but to our whole social life.

Looking at specific professional schools, we may note the following:

MEDICAL SCHOOLS, SCHOOLS OF NURSING, SCHOOLS OF SOCIAL WORK

All three of these are now providing increasing opportunities for students to gain understanding of mental health and a recognition of their role in fostering mental health through their usual professional work. All three of these schools are now training psychiatrists, psychiatric social workers, and also psychiatrically oriented nurses, to some extent.

There is no generally accepted pattern for this training nor are there enough well-trained teachers to provide the necessary instruction in these schools. What is especially needed is a clearer recognition of how the physician in the home, the clinic, and the hospital, along with the nurse and the public health nurse, can advance mental health in and through their personal as well as professional relations with all their patients as they apply their specialized knowledge and skills.

It is especially important that medical students learn more about family living, parent-child relationships, child growth and development, aging, personality development, school health needs, and how to work with social workers, teachers, and other professionals in the community.

Because of their professional responsi-

bilities for therapy, the emphasis in teaching is primarily on diagnosis and treatment of mentally ill or disturbed personalities. An understanding of how, as professionals, they can function in and through community mental health programs is urgently necessary.

DENTAL SCHOOLS

Dentists, especially those treating children, should be better oriented to children as developing personalities so that in their work they will give reassurance and avoid traumatizing their child patients. This also applies to other specialists who treat children.

LAW SCHOOLS

Lawyers serve as advisers to individuals, families, and organizations, especially business and industrial, where their advice and counsel are directly concerned with human relations, with disputes, conflicts, and industrial relations, and with marital and parent-child relations. Lawyers also serve as legislators and as judges; they make judgments and decisions of far-reaching significance for mental health upon a variety of issues, including the many forms of deviations known as crime and delinquency, divorce, etc.

For the most part, law students are trained in the familiar conception of a rational human nature, of human motivations of the older, voluntaristic beliefs, and they carry these assumptions into their legal careers where their ignorance of, resistance to, or rejection of new understanding and insights constitute one of the major obstacles to the development of mental health. As legislators, lawyers with their older assumptions and beliefs are blocking many urgently needed changes in all areas of social life, especially provisions for better care of the

mentally ill and for mental health services for all areas of life.

It would be appropriate to introduce law students to dynamic conceptions of personality through courses on contracts, torts, criminal law, evidence, and domestic relations and to give them an understanding of the clinical approach which has been accepted in many juvenile courts and is now being advocated in divorce and family courts.

SCHOOLS OF EDUCATION

The school teacher is potentially the most important professionally trained individual in the development of mental health. Next to the home and parents, the school and the teachers are in the most promising position to foster mental health in the classroom through direct relations with the class as a group and with individual pupils.

Especially in adolescence, when boys and girls are often in conflict with their families, the high school teachers can be of immense help to students when they have some understanding of the problems of that age group and some insights into the relationships they have with students.

Increasingly, schools of education, including teachers' colleges, are giving courses in child development and utilizing nursery schools for observation. But student teachers are not receiving systematic training in the newer concepts of personality development and are still being taught educational psychology derived primarily from animal experiments about learning that ignores the emotional and other human aspects of learning, especially symbolic learning.

In university schools of education, where many of the leaders and administrators of school systems are being trained, failure to provide understanding of what mental health means in schools is perpetuating the

resistance to much-needed changes in classrooms and is defeating the efforts of these teachers who are trying to infuse their work with mental health understanding.

THEOLOGICAL SEMINARIES

The clergy have a close, intimate relationship to families and children; they are probably more frequently called upon for advice and guidance in times of family and personal crises than any other professional group. While a few theological seminaries are beginning to offer some orientation in mental health to their students, the majority are still teaching the older conceptions of human nature and are training students to maintain the traditional moralistic approaches to human difficulties.

The Council on Clinical Training is fostering specific training among the Protestant clergy through internship in mental hospitals and is concerned with the earlier orientation of theological students.

Again, the emphasis is upon understanding individual conflicts and personality disturbances, so that the teacher-minister may not receive much orientation to the tasks of community mental health in which he can actively participate with others.

As the churches recognize that the mental health movement is predicated upon the traditional religious belief in the worth of the personality and human dignity, including the dignity of the child, they can utilize their immense influence and their close relationships with families to foster mental health. What is perhaps as important will be the diminution of the present theological emphasis upon an evil human nature and upon creating and intensifying guilt feelings and the acute conflicts now being fostered by some of the accepted teachings of the churches.

Recently there has been a promising movement to revise the traditional Sunday

school programs by recognizing the new understanding of child development and the so-called "child-centered" approach in education.

The churches are potential allies of mental health and can be more actively enlisted in the movement as the present programs of theological schools are reoriented and as ministers in service are given some reorientation, as in the publication of *Pastoral Psychology*.

SCHOOLS OF PUBLIC HEALTH

Mental health as a community-wide problem is emerging as a specific responsibility of public health. The American Public Health Association now has a section on mental health and many public health administrations are active in mental health programs. However, many students of public health are not receiving the orientation and understanding needed for accepting these larger responsibilities or for infusing mental health into their present activities, such as prenatal and well baby clinics. The schools of public health are recognizing the task of health education as their professional obligation, but, for the most part, are unaware of the need for insights into the individual's beliefs and attitudes toward his or her own body and the importance of recognizing personality and emotional reactions in order to make health education effective.¹

Because public health agencies and personnel will be increasingly involved in preventive medicine and health care, they will need further training in mental health thinking and practices.

¹ Frank, Lawrence K., "Health Education," *American Journal of Public Health*, 36(April, 1946), 357-66.

SCHOOLS OF PUBLIC ADMINISTRATION

The development of graduate schools of public administration to train personnel for service in local, state, and national governmental organizations marks a significant trend of great promise. The graduates of these schools are being drawn into governmental service and are becoming responsible supervisors and policy makers or advisers to top executives. In these capacities they are concerned with a variety of problems that have large mental health implications, including the important question of maintaining the efficiency and morale of civil service employees and meeting the many disputes and conflicts arising in these services, such as the police force, fire departments, sanitation departments, and the employees of municipal public utilities, transportation, electric light, and water supply. The mental health of police is becoming an urgent problem in view of many disturbed policemen who act irresponsibly and often violently, including suicide.

The students of public administration are a strategic group for whom an understanding of mental health is greatly needed if they are to play their roles effectively and to help advance mental health programs in their communities, especially in cooperation with other professional agencies.

SCHOOLS OF ENGINEERING AND ARCHITECTURE

Schools of engineering and architecture are preparing personnel for professional work that has a direct bearing upon mental health objectives.

Engineers are now designing factories, machinery, technological processes, vehicles, highways, setting up industrial organizations, and increasingly determining the

physical conditions under which men and women must work. Because the engineering students are primarily trained in physical sciences, mathematics and engineering techniques, plus some training in economics, they are usually ignorant of, and indifferent to, human relations and the direct impact of their professional decisions and practices upon human living. While engineering schools are increasingly offering programs in humanities, these courses are largely reading and discussion of historical material which may enlarge the student's awareness and understanding in those areas, but do not give him an awareness of his responsibility for mental health in his professional practice in the world of today.

In consequence of their narrow assumptions and practices, efforts to foster safety, health protection, industrial relations, and mental health must be carried on independently and often against formidable physical and mechanical obstacles created by the engineers who are unaware of what they are doing, or failing to do, in their professional work.

It seems clear that if engineers were given some understanding that all their factories, machines, processes, highways, vehicles, etc., were necessarily to be used by people whose feelings, behavior, and relationships were largely controlling, then the engineering profession might contribute to, rather than impede, the mental health movement.

The problem is to convince the engineering student that, in all his work, he is acting upon assumptions about human nature and social order, with expectations of what people will do and not do, that are no longer adequate, and that the insight and understanding of mental health will make it possible for him to increase the effectiveness and productivity of the things he designs and builds because they will be more nearly in accord with what we know now

about human behavior and emotional reactions.

Architects, likewise, are engaged in designing buildings for use by people—employees in factories and offices, pupils or students in schools, patients in hospitals and clinics and other institutions, and members of families in housing developments or individual homes. Few, if any, architects have had any orientation in mental health, in understanding the dynamics of family life, the requirements of homemaking today, and how in the design, equipment, and construction of buildings, many of the objectives of improved living and mental health could be greatly facilitated. This is especially important for the growing number of older persons for whom better housing is needed.

The importance of providing homes that are specifically designed to foster family living, including more adequate provision for child care and rearing, cannot be over-emphasized. At present, we are exhorting families to accept the new knowledge and put into practice improved ideas of house-keeping, home management, nutrition, sanitation, safety, health care, and mental health; at the same time we expect families to accept and apply ideas in housing that not only ignore these needs but often perpetuates the older assumptions and designs that make improved living difficult, if not impossible.

Few, if any, schools of architecture now give their students any systematic instruction in family living, what it involves today, the changing functions and responsibilities of the home, especially with the wife-mother working for wages, or the dynamics of family relationships during the family life cycle. Few give any instruction in child growth and development, what homes need to provide for improved child care and rearing, and for physical and mental health. Few

architects have any realization of what opportunities there are in housing developments to provide what families so urgently need to meet their greatly enlarged parental responsibilities today and to maintain some balance and sanity in the midst of the disorder and confusion in our social order.

SCHOOLS OF PLANNING

Students are now being trained for regional and urban planning, focused largely upon physical planning, with the chief concern on site planning, zoning, traffic, circulation, and the various provisions for physical operations and needs such as water supply, sanitation etc. While the planner is in a strategic position to advance mental health through his work of planning an orderly, efficient design for living in a given area, few planners are aware of their many opportunities to promote mental health through their planning.²

Not only can the planner seek to reduce the many unnecessary stresses, conflicts, and other burdens upon people, but he can also plan for ways of living, working, and recreating which will enable people to cope more effectively with their life tasks and to find fulfillment of their many needs and aspirations. The planner is in a position to orchestrate the many diverse activities and arrangements so that they can be oriented to a more coherent and humanly desirable way of living.

SCHOOLS OF JOURNALISM, COMMUNICATIONS, AND PUBLIC RELATIONS

Schools of journalism are engaged in training students for work on newspapers and other publications and in providing in-

² White, Richard, *Planning for Mental Health* (Massachusetts Institute of Technology, student thesis, 1957).

service training for working newspaper men. But, again, these students receive little or no orientation in mental health and have no systematic instruction in the new understanding of personality and human relations. Since the newspapers are the chief instruments for interpreting events, especially human conflicts and interpersonal relations, it is important that these few university trained journalists be given some understanding of what mental health means. Beyond the current practice of exposing conditions in mental institutions and whenever possible ridiculing and attacking psychiatrists, newspapers are unaware of mental health, except for a few feature writers in one or two of the large metropolitan newspapers.

The schools of journalism should be made aware of their social responsibilities in this area, of the need to give reporters and rewrite men a better understanding of what they are now doing, and failing to do, in mental health, and how they are perpetuating the archaic beliefs about human nature in their papers.

Those schools which are training personnel for work in communications through the mass media of radio and television and through public relations activities also have a large potential contribution to mental health. The frequent misleading, confusing, and sometimes highly disturbing presentations are inimical to mental health and call for change. To avoid the threat of censorship, communication workers should be made aware of what they are now doing to invite censorship and helped to understand how they can contribute to mental health through their professional work.

SCHOOLS OF HOME ECONOMICS

In every state university land grant college, also in many other colleges and universities, including teachers' colleges, and in many high schools, home economics courses are

being taught with little understanding of the personality and emotional aspects of home and family living. Fortunately, a growing number of teachers are attempting to provide their students with more understanding of family dynamics and the family life cycle and are offering observations in nursery schools along with courses in child development. A systematic reorientation of all home economics courses, including those in extension services, under state and federal auspices, would make these programs more effective for mental health, improved family living, and child care and rearing.

COLLEGES OF AGRICULTURE AND FORESTRY

A considerable number of the graduates of these colleges become teachers, extension workers, and administrators of state and federal programs dealing directly with people living on farms. Their work is primarily that of re-education, persuasion, and redirection of those engaged in agriculture who today are undergoing extensive alterations in their customary practices and modes of living. Thus, they are dealing with people, many of whom are undergoing considerable tension and conflict which might be allayed if these workers had more understanding of mental health and how to deal with the frequent resistances they encounter in their work.

GRADUATE SCHOOLS OF SOCIAL AND BEHAVIOR SCIENCE

Students today are being trained as economists, political scientists, social psychologists, sociologists, and anthropologists, largely in terms of the eighteenth and early nineteenth century conceptions of human nature and conduct and of social order, which they apply later in their teaching and in their various activities as advisers, policy makers, administrators, etc.

It is indeed curious, and, in the long run, will be increasingly tragic, that many of

those who are being trained to do social research and to guide our society in meeting its many difficult social problems are operating with these obsolete conceptions of human nature, ignoring or rejecting the recently developed insights into personality and the new understanding of human behavior in economic, political, and social activities.

A few institutions are providing the students of social psychology, of sociology and anthropology, and of political science with some orientation in dynamic psychology, but it is safe to say that the bulk of the graduate work in American universities is carried on in terms of the ideas of Locke, Hume, Bentham, and those who have elaborated these earlier ideas of human nature and human behavior and of social order, with emphasis upon quantitative studies.

The consequences of this continued indoctrination of students of social science in these obsolete assumptions are far-reaching today when social scientists are playing increasingly active roles as advisers in government, in business, and indirectly in public affairs generally.

It is imperative that these graduate students be given some awareness of new ideas and of their implications for their specific disciplines and for thus enlarging activities outside the university.

Clinical psychologists are also being trained in universities chiefly in the departments of psychology which emphasize experimental studies. These clinical psychologists constitute another growing professional group whose participation in fostering mental health may be increasingly important as their training is refocused.

Recent federal legislation aims to increase the number and improve the training of individuals for work in counseling and guidance in schools, especially in high schools. These students need, in addition to the

usual training in tests and measurement, more understanding and clinical experience, so that in their professional work they can further the mental health of their own students.

TEACHERS OF ART, MUSIC, DANCE, DRAMA, AND PHYSICAL EDUCATION

All of these teachers are in a position to contribute to the mental health of students when they have an awareness of how their teaching can provide individual students with much needed opportunities for the discovery of self and for finding release and fulfillment through these activities. If all these teachers had the understanding and skills which a few leaders in each area now exhibit, it would be possible to make our high schools more effective agencies for the promotion of mental health of adolescents. This does not mean making the teachers into "amateur psychiatrists" but rather helping them to discover how to use the subjects and activities they teach in ways that are more appropriate for the mental health of their students.

As the foregoing indicates, a concerted effort to enlist all the professions in the mental health movement would greatly enlarge resources for this task. Since the need is similar in all the professional schools, it would be desirable to plan a co-operative program to help all these different professions by providing the material and the assistance which each could adapt to its own special needs and requirements. This could be done by establishing a Commission on Professional Education.

Obviously no immediate results should be expected, but the fruits of such a program should begin to be cumulatively apparent in the years ahead as these various professional workers take their places in the community and begin to practice with this new orientation.

Statistics of admissions to and discharges from state schools for mental defectives

According to the Biometrics Branch of the National Institute of Mental Health, there were 129,187 patients on the books of the 97 public institutions for mental defectives in the United States at the close of fiscal year 1954 (1). Of this total, 113,960, or 88.2 per cent, were in residence. The resident population had grown by 20,000 during the previous decade. This did not result from any marked increase in admissions, because the annual admissions grew during the same period by only 2,685. The increase was caused by the excess of admissions over removals. In 1954, for example, there were 11,577 admissions to the public institutions for mental defectives (excluding transfers),

1,223 discharges from institutions, and 1,930 institutional deaths. Even with adjustments for extra-mural care, the admissions were in substantial excess. The death rate among institutionalized mental defectives has decreased in recent years. If the population of these institutions is to be reduced, or even stabilized, in number, this must come from an increase in the rate of discharge. Up to 1954, there had been a decreasing trend in such rates, however. In 1941, the public institutions had a discharge rate of 48.9 per 1,000 average patients on the books. This increased to 54.4 in 1943 but fell to 36.9 in 1954.

New York state has the longest series of statistical data with respect to movement of patients in state schools for mental defectives. There are six such schools. They date from 1855 when the Syracuse State School was opened. From the beginning,

Dr. Malzberg is principal research scientist for the Research Foundation for Mental Hygiene, Inc., Albany, N. Y. His investigation was supported by a research grant from the National Institute of Mental Health.

this school has been directed primarily to the higher grades of mental deficiency. A second state school was opened at Newark with provision for patients who were not adapted to the classroom type of instruction provided at Syracuse. In 1893, a third state school (for unteachable mental defectives) was opened at Rome.

These schools are in central New York, and provision for New York City was inadequate. A fourth state school, Letchworth Village, was therefore opened in 1911 and received patients from New York City. The growth of the general population resulted ultimately in overcrowding of the state schools. It became necessary to erect an additional school. The site chosen is in Dutchess County where the Wassaic State School was opened to patients in 1931. Further growth of population again made it necessary to build a new school. The new site is on Staten Island where the Willowbrook State School was opened in 1948.

These six schools are administered centrally by the New York State Department of Mental Hygiene. Three schools are relatively close to New York City. The other three serve the remainder of the state. Syracuse State School limits admissions to the higher grades of mental defect. Willowbrook gives special consideration to very young and low-grade defectives. The other schools accept defectives of all grades.

The need for expansion continues, however, and a new school is under construction in the western part of the state, near Buffalo. The other end of the state will benefit from the construction of a new school in Suffolk County. An additional school will be constructed in Brooklyn to care for defectives who are severe behavior problems in the other schools.

The existing schools had 24,148 patients on the books in March, 1958. Estimates of

the prevalence of mental deficiency vary, but if we accept the statement that approximately two per cent of the population of school age is defective, this implies that there are about 85,000 defectives in this age group in New York state. If one per cent of the total population is defective, this implies that there are about 170,000 defectives in the state. If only half of these need specialized care, we have a total of 85,000 defectives, compared with only 24,000 under treatment currently. If we limit the estimate to the child population, and assume that half of the defectives in this age group require institutionalization, this would still be twice the actual population of the state schools. Admission to the schools must, therefore, be selective and limited largely to those in urgent need. Therefore, the population of the state schools is not a random selection of all defectives. There are differences with respect to age and sex distributions, and the younger undoubtedly include a higher proportion of imbeciles and idiots. This selection influences rates of mortality (2) and will also be shown to have an important effect upon rates of discharge.

Table one provides a summary of the number of patients on the books of the New York state schools for mental defectives from 1930 to 1958. The population grew from 9,046 in 1930 to 18,144 in 1942. It fell, during the war, to 17,971 in 1944 but has since risen to 24,148. The sex proportion of the book population has varied. Prior to 1946, females were generally in excess, but males have been more numerous subsequently.

The rate per 100,000 population grew to 144.6 in 1945 but declined to 131.1 in 1948. The rate grew to 146.4 in 1956 and to 145.2 in 1958. Since 1936, the male rate has exceeded that for females.

Table two provides a summary of the

TABLE I

Number of patients on the books of New York state schools for mental defectives

YEAR *	NUMBER			RATE PER 100,000 POPULATION		
	Males	Females	Total	Males	Females	Total
1930	4,293	4,753	9,046	67.9	75.6	71.7
1932	5,285	5,653	10,938	82.6	88.4	85.5
1934	6,359	6,568	12,927	98.2	101.1	99.7
1936	7,348	7,391	14,739	112.2	112.0	112.1
1938	8,187	8,063	16,250	123.6	120.4	122.0
1940	8,835	8,663	17,498	131.9	127.4	129.6
1942	9,107	9,037	18,144	143.4	133.0	138.0
1944	8,904	9,067	17,971	145.7	138.5	142.0
1946	9,127	9,177	18,304	142.0	136.6	137.4
1948	9,426	9,330	18,756	136.4	126.1	131.1
1950	10,238	9,853	20,091	143.0	128.4	135.4
1952	10,886	10,250	21,136	148.2	130.3	138.9
1954	11,727	10,712	22,439	154.7	132.0	142.9
1956	12,540	11,135	23,675	160.7	133.2	146.4
1958	12,820	11,328	24,148	159.6	131.7	145.2

* June 30 through 1942; March 31, thereafter.

resident population, which includes those in colonies and in family care. The resident population represents, currently, approximately 97 per cent of the book population. The growth of the resident population is caused, in part, by a decrease in convalescent care. Except for a decrease in 1944, the resident population has increased steadily to a maximum of 22,581 in March, 1958. The introduction of tranquilizing drugs in recent years slowed the rate of growth but did not cause a decrease in the resident population. Since 1935, the rate per 100,000 population has been higher for males than for females.

FIRST ADMISSIONS

Despite the growth of population, there has been no correspondingly great increase in

the number of first admissions. Such admissions depend, in large part, upon increases in capacity. Thus, there was a marked increase in 1932 following the opening of Wassaic State School. However, this was followed by a decreasing trend through 1944. The number of first admissions has since risen, caused, in part, by the opening of Willowbrook State School. Male first admissions exceed females primarily because of behavior problems which make it more urgent to admit males.

The rate of first admissions per 100,000 population rose rapidly between 1928 and 1933, but this was followed, from 1933 to 1944, by a significant decrease. The rate rose slowly between 1944 and 1954 although it remained far below the maximum, which was reached in 1933. The rate has been

declining again since 1954. Throughout the years, the rate per 100,000 males has exceeded that for females.

Significant changes have occurred among first admissions with respect to the relative distribution of the levels of intelligence. The percentage of idiots showed a downward trend between 1930 and 1940 but has since increased steadily to a maximum of 22.3 in 1956. Imbeciles, too, showed a rising trend almost without interruption between 1930 and 1956. Corresponding to these increases, there was a reverse trend for the morons. This group constituted 56.3 per cent of all first admissions in 1930, but the percentage fell, with minor fluctuations, to 38.9 in 1956.

The increase in defectives of low intelligence cannot be imputed to an increase in their numbers among the unselected population of mental defectives. The change in

trend must be attributed to growing social pressure to admit very young defectives to the state schools. Idiots, especially, form a large part of the admissions of this age group.

The pressure for the admission of the very young was first noted in 1946. In that year, first admissions aged less than five years included 8.5 per cent of the total first admissions. This percentage grew year by year, reaching 26.0 in 1954. The percentage fell slightly to 24.3 in 1956, still well above that of the previous decade.

DISCHARGES

The rate of discharge per 1,000 patients under treatment has varied significantly since 1930. It declined between 1930 and 1940, then increased through 1944. This was associated with circumstances during World War II when it was possible to find

TABLE 2

Number of resident patients in New York state schools for mental defectives

YEAR *	NUMBER			RATE PER 100,000 POPULATION		
	Males	Females	Total	Males	Females	Total
1930	3,853	4,159	8,012	60.9	66.1	63.5
1932	4,890	5,103	9,993	76.4	79.8	78.1
1934	5,846	5,932	11,778	90.3	91.4	90.8
1936	6,606	6,580	13,186	100.9	99.8	100.3
1938	7,343	7,248	14,591	110.9	108.2	109.5
1940	7,852	7,740	15,592	117.2	113.8	115.4
1942	7,993	7,915	15,908	125.9	116.4	121.0
1944	7,998	8,039	16,037	130.9	122.8	126.7
1946	8,299	8,156	16,455	129.1	118.4	123.6
1948	8,711	8,472	17,183	126.1	114.5	120.1
1950	9,602	9,081	18,683	134.1	118.4	126.0
1952	10,249	9,414	19,663	139.4	119.7	129.2
1954	11,140	9,970	21,110	147.0	122.9	134.6
1956	11,795	10,340	22,135	151.1	123.7	137.0
1958	12,053	10,528	22,581	150.0	122.4	135.7

* June 30 through 1942; March 31, thereafter.

TABLE 3

First admissions to New York state schools for mental defectives

FISCAL YEAR	NUMBER			AVERAGE ANNUAL RATE PER 100,000 POPULATION ¹		
	Males	Females	Total	Males	Females	Total
1930	577	623	1,200	8.8	8.1	8.4
1932	1,005	939	1,944	13.8	12.1	12.9
1934	871	774	1,645	14.9	12.8	13.8
1936	869	788	1,657	14.6	12.4	13.5
1938	933	769	1,702	13.8	11.4	12.6
1940	768	627	1,395	12.3	9.6	10.9
1942	762	614	1,376	11.7	9.3	10.4
1944	700	500	1,200	10.9	8.4	9.6
1946	764	522	1,286	11.5	8.3	9.9
1948	705	586	1,291	10.9	8.3	9.6
1950	868	634	1,502	11.7	8.4	10.1
1952	819	684	1,503	11.6	8.7	10.1
1954	911	748	1,659	11.9	8.9	10.3
1956	938	674	1,612	11.9	8.5	10.1

¹ Based upon average number of first admissions during 3 consecutive years, i.e., rate for 1930 is average for 1929-1931, inclusive.

employment, especially for males, thus permitting the discharge of an increased number of patients. Since the end of the war, both the number and rate of discharge have declined steadily. The trends are strikingly similar for males and females although the rate for males is consistently higher than that for females.

Rates of discharge are available since 1940 in relation to mental status. Rates for idiots are understandably low and ranged, during this period, from a minimum of 7.3 per 1,000 under treatment to a maximum of 9.4. Because of the small number of discharges, the rates fluctuated abruptly within these extremes. Nevertheless, rates for males were significantly higher than those for females.

The rate of discharge rose significantly higher among imbeciles, varying from a minimum of 16.1 to a maximum of 30.9.

The rate rose to the maximum in 1944 and has since dropped steadily to a minimum in 1954. The maximum rate of discharge occurred during the war years. There was a great similarity in trends for males and females although rates for the former were in significant excess throughout.

A further increase in rates of discharge occurred among morons. These fluctuated between 62.1 and 118.1. The rates rose to a maximum in 1943 and 1944 and declined steadily, except for a minor rise between 1950 and 1952, to a minimum in 1955. The male rates exceeded those for females up to 1951. In recent years, females have had higher discharge rates than males.

The downward trend in discharges is, in itself, a contributing factor to the continuation of the trend. Those who continue in residence have a lesser probability of subsequent discharge, since the rate of discharge

is related inversely to the duration of residence.

Rates of discharge, when based upon the total under treatment during the year, tend to be underestimated, because the latter total is weighted with patients with long periods of prior duration of residence. The most accurate measure is obtained by computing the duration of residence from the date of first admission to the date of discharge. This method (cohort analysis) was applied in a study of discharges among first admissions to the Pacific State Hospital in California during the period 1948-1952 (3). There were 722 first admissions during this period.

The most significant findings were as follows: Of the 722 first admissions, 13.9 per cent were discharged within a year after admission. During the entire period of observation (four years), 36.8 per cent were discharged. The discharges decreased with

the flow of time, only 5.6 per cent being discharged during the fourth year, compared with 13.9 per cent during the first year. There were some sex differences although they do not appear significant. Thus, 14.7 per cent of the males were discharged within a year, compared with 12.7 per cent of the females. During the four years, more females were discharged, however, the percentages being 38.2 for females and 35.8 for males.

The probability of discharge (per 1,000) varied directly with age at first admission. During the first year of hospitalization, they rose from 0.031 among those aged 0-4 years to 0.287 among those aged 16-17. The probabilities of discharge decreased as the duration of hospitalization increased. For example, for all patients, the probability decreased from 0.139 during the first year to 0.096 during the fourth year. Within each period, however, the probability of release

TABLE 4

Distribution of first admissions to the New York state schools for mental deficiencies, in per cent,² according to mental status

FISCAL YEAR	IDIOT	IMBECILE	MORON
1930	11.6	25.2	56.3
1932	13.9	27.3	53.1
1934	10.5	27.1	54.4
1936	10.3	31.6	53.3
1938	10.3	30.2	51.9
1940	9.3	30.8	51.1
1942	9.7	32.3	52.9
1944	12.4	30.3	56.1
1946	13.4	32.8	51.8
1948	15.9	34.1	48.3
1950	16.9	38.8	43.3
1952	18.0	39.6	41.4
1954	20.8	40.1	38.2
1956	22.3	37.5	38.9

² See footnote to Table 3.

TABLE 5

Average annual discharge rate per 1,000 patients under treatment in New York state schools for mental defectives, classified according to mental status

FISCAL YEAR	TOTAL			IDIOT			IMBECILE			MORON		
	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
1930	77.4	56.5	66.7	•	•	•	•	•	•	•	•	•
1932	62.3	52.0	57.1	•	•	•	•	•	•	•	•	•
1934	67.7	57.8	62.8	•	•	•	•	•	•	•	•	•
1936	68.3	54.4	61.4	•	•	•	•	•	•	•	•	•
1938	61.0	52.1	56.6	•	•	•	•	•	•	•	•	•
1940	59.7	43.6	51.8	8.9	5.6	7.3	24.4	21.6	23.1	107.3	71.9	89.4
1942	74.4	52.8	63.7	9.8	6.0	8.0	31.8	25.8	28.9	138.3	90.2	113.7
1944	76.4	52.9	64.7	10.5	8.1	9.4	35.8	24.9	30.6	144.0	98.0	117.6
1946	66.2	51.5	59.6	10.3	5.5	8.0	31.4	22.7	27.2	131.1	97.2	113.6
1948	51.9	47.6	49.8	8.8	6.7	7.7	27.4	23.4	25.4	102.7	91.4	97.0
1950	39.7	38.3	39.0	9.0	7.2	8.2	22.9	19.8	21.4	76.4	75.3	75.9
1952	39.7	38.6	39.2	8.8	5.9	7.4	20.9	17.8	19.4	82.7	82.9	82.8
1954	32.6	34.0	33.3	7.3	6.1	6.8	16.9	15.6	16.2	71.2	76.6	73.8
1956	32.6	31.3	32.0	9.6	7.7	8.7	17.9	15.7	16.9	65.6	63.8	64.7

• Data not available.

increased with advancing age at admission. During the second year, the probability rose from 0.031 at ages 0-4 to 0.354 at ages 16-17. During the fourth year, they rose from 0.050 to a maximum of 0.163.

These probabilities vary with the intelligence quotient, which is equivalent to stating that they vary with mental status. They were lowest among idiots (I.Q. 0-19). For this group, the probability of release was 0.048 during the first year, with a decrease to 0.015 during the fourth year. The probabilities rose among those with I.Q. 20-49 (imbeciles) and rose still higher among morons. Those with I.Q. 50-69 had a probability of discharge of 0.227 during the first year, which declined to 0.194 during the fourth year. Those with I.Q. of 70 and over had the highest probability of discharge. It was 0.298 during the first year and 0.238 during the fourth year.

As the range of I.Q. varies with the clinical classification, one would expect the latter to show variations of discharge rates. Thus, the clinically undifferentiated group, which includes a high proportion of morons, had a probability of discharge of 0.196 during the first year. This rose to 0.228 among the familial group. On the other hand, groups with high proportions of low I.Q.'s had low probabilities of discharge. Among mongols, it was 0.048 during the first year. Among cases resulting from trauma, the probability was 0.075. Among those resulting from infection, it was 0.056.

SUMMARY

1. The number of first admissions depends primarily upon the capacity of the state schools. In 1932, the number of such admissions increased in New York state to a total of 1944, because of the opening of Wassaic State School. Admissions decreased thereafter until 1950. The opening of

Willowbrook State School permitted a rise in first admissions to over 1,600.

2. Because of selection of patients, there has been a significant increase in recent years of the relative proportions of very young first admissions of low mental status to the New York state schools.

3. The resident population of these schools has almost tripled since 1930. The increase primarily is the result of the excess of admissions over removals.

4. In general, the rate of discharge has declined since 1930. An exception occurred in 1944. At that time, the war created a demand for labor, so that it was possible to find employment for many patients, thus permitting discharge.

5. Rates of discharge vary with mental status. They are lowest among idiots, intermediate among imbeciles, and highest among morons.

6. Studies of discharge rates by cohort analysis give more accurate results. They show that 13.9 per cent of first admissions were discharged within a year after hospitalization and that 36.8 per cent were discharged within four years.

7. The rates of discharge decreased as the period of hospitalization lengthened.

8. The rates of discharge varied with age at first admission, being lowest for the youngest groups.

9. The rates of discharge vary directly with I.Q. at time of admission.

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Minnesota's progressive community mental health services

Based on the Community Mental Health Services Act of 1957 (1), which has been classed as model legislation and recommended to the Council of State Governments, a varied, challenging, and responsible program in the field of community mental health has been set into operation in Minnesota. Its early development has been previously described (2). The following is an account of the principles on which this program is based, the services offered, and the progress since its inception.

UNDERLYING PRINCIPLES

1. *The program is permissive.* A community may take advantage of state support and consultative services but is not under any obligation to do so. The initiative, then, rests with the community.

planning. All local concern with mental

TABLE 5

Average annual New York classification

Community Mental Public Welfare, St.

health participate in the planning of a comprehensive community mental health service. The goal is a network of services within each community. Each center is staffed by a highly qualified professional team comprised of psychiatrist, psychologist and social worker.

3. *Local control with state support.* While each center must meet certain standards in terms of professional qualifications, range of program, accounting, etc., the planning proceeds at a local level, and the operating responsibility and administration rests with the participating communities.

4. *Matching grants-in-aid.* Up to one-half the costs involved may be reimbursable by the state to a maximum of \$.50 per capita. Local financial support for most centers is derived from general county tax revenue. Where this is insufficient, there is provision for a special levy for community mental health. Private and voluntary public donations (Community Chest) are en-

couraged. Local fee schedules may be established within certain limits (3). The minimum population base is ordinarily 50,000 for each center, the current range being 50,000 to 140,000, with an average of 80,000.

5. *Social orientation.* While direct clinical or outpatient services are provided at all centers, other important foci of attention are consultation, information, and educational services to lay and professional groups, collaboration with other agencies, promotion and development of additional community resources for mental health, training, and even research. The preventive aspect of the program and the effort to achieve full coordination and utilization of all community resources, in a continuous and comprehensive manner, gives each program a broad social base.

Typically, several counties collaborate in supporting a program tailor-made to their particular needs. The flexibility of the program is particularly evident here in the variation of services provided at the different centers throughout the state. The open-ended nature of the clinical contacts, the new and somewhat broader and more responsible level of professional service, the emphasis on community as distinct from clinical services, the relatively greater professional freedom possible in non-civil service situations, the opportunity to develop an exemplary service, the encouragement offered all professional staff to undertake private practice, the maintenance of high professional standards, and the realistic and competitive salaries offered have drawn considerable professional interest in this program. It has been possible to fill all vacancies in all professions within the first year of operation of each center and, more

important, personnel turnover is almost nonexistent.

BROAD RANGE OF SERVICES

1. Collaborative and cooperative services with public health and other groups for programs of prevention of emotional and mental disorders;
2. Informational and educational services to the public, lay, and professional groups;
3. Consultative services to schools, courts, welfare, health, correctional, rehabilitation, and other agencies;
4. In-service training programs for general practitioners, teachers, nurses, clergymen, caseworkers and others;
5. Serve as a focus of mental health activities within the community and, through in-service training, demonstration and other means, promote and further the development of existing and additional mental health and related resources throughout the area served (e.g. school psychologists).
6. Outpatient diagnostic and treatment services;
7. Rehabilitative services, particularly for patients discharged from state institutions;
8. Participation in monthly statistical reporting, in research projects and surveys; and
9. Other less typical but no less important functions such as mental health consultation in industry, the establishment of a regional mental health reference library, etc.

Because of the broad range of services provided with an emphasis on the community in addition to the more traditional clinical services, we refer to these facilities as mental health centers rather than clinics.

Administrative responsibility for the policies at each center rests with a nine-member mental health board selected under the terms of the law to represent nine specific areas of interest within the community. At the staff or professional level, the day-to-day operation of the center is in the charge of a program director appointed by the board. The director is selected for his administrative experience or talent and may be either the psychiatrist, psychologist, or social worker. Medical responsibility is seen as a distinct concern which must be assumed by the psychiatrist.

The current biennial appropriation from the state legislature of \$770,000 (\$342,000 in the first, 1957-59, biennium of the program) now fully committed, has enabled the establishment of comprehensive mental health services which embrace 48 counties (87 within state) and are directly available in the community for some 42 per cent of the state's three and one-half million population. Prior to the passage of the act in 1957, the state maintained two all-purpose mental hygiene clinics, a follow-up clinic, and an alcoholism clinic. In addition, there were four private agencies which provided out-patient mental health services. (The follow-up clinic closed June 30, 1960, and the alcoholism clinic will be re-integrated with the state hospital program thus bringing to an end in Minnesota the era of the state-operated clinic.) Since the passage of the Act, three of the private agencies have received grants to add to staff, while the fourth (Duluth), has expanded its program through matching state grants-in-aid. The two all-purpose mental hygiene clinics (Albert Lea and Fergus Falls) have converted to community mental health centers and are no longer under state operation. During the first biennium, that is

1957 to 1959, three new centers were established (Crookston, Willmar and Austin) and one former center reopened (Rochester), and then in July, 1959, grants were made to four more centers (St. Cloud, Grand Rapids, Marshall, and Luverne) to begin operation. Since then, applications from two additional groups (Owatonna and Bemidji) have been approved, and these became active in April and May, 1960. Several other applications are pending, and more than a dozen additional counties have demonstrated active interest. A total of \$504,000 in grants and operating costs has been approved for 1960-61, with grants to county-supported centers ranging from \$23,000 to \$60,000 (average, \$32,000).

Thus, in less than three years, it has been possible to expand or establish and staff services at no less than 16 centers throughout the state. To really measure this accomplishment, it must be pointed out that Minnesota is largely comprised of rural communities, and this poses special problems in developing comprehensive programs and recruiting qualified personnel. On the basis of strong legislative and wide public support and on the increasing demand for additional services and centers, the only possible prediction is further progress.

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Book Reviews

EARLY EDUCATION OF THE MENTALLY RETARDED

By Samuel A. Kirk

Urbana, Ill., University of Illinois Press, 1958.
216 pp.

The age-old battle of heredity versus environment, or nature versus nurture, continues unabated, in spite of many protestations about the futility of this conflict. Philosophically, one can hover above the battle, and remain aloof from it. When confronted with live issues and living children, however, one cannot remain aloof; burning questions urgently press for valid answers, and these must somehow be obtained even if basic theoretical problems have not as yet been satisfactorily solved.

In *Early Education of the Mentally Retarded*, Kirk and his associates at the Institute for Research on Exceptional Children at the University of Illinois not only raise these questions but come to grips with some fundamental issues related to the growth, development and education of young educable mentally retarded children (as against "trainable," or lower level mentally retarded). Kirk is disturbed by some existing practices and beliefs connected with the education of mentally retarded children. They are frequently admitted to regular schools at age five or six and, when unable to function normally, are discharged and re-admitted several years later in the hope that maturation will occur; or they may be permitted to fail for several years, kept with younger children, and later admitted to special classes. Special classes frequently do not exist in the first years of school. Kirk also questions the common belief that a child cannot function beyond a predetermined level established by a properly obtained intelligence test score, and raises the

issue of home versus foster home or institution for some children.

Early Education of the Mentally Retarded is a report of a five-year study with 81 educable mentally retarded children between the ages of three and six. These were divided into four groups: a community experimental group of 28, an institution experimental group of 15, and a "contrast" group for each of these. Individual psychological examinations were administered at the outset and at regular intervals thereafter; social and adjustment data were collected periodically. The experimental community group attended a preschool, while the contrast group did not; the experimental institution group attended a preschool in the institution, while that contrast group did not. All were re-tested and followed up at the same intervals.

Of the 43 experimental children, 70% showed acceleration in rate of growth considerably above the expected rate, and I.Q.'s as well as social quotients showed significant increases over those of the contrast groups. Even children with organic defects showed gains, though not as great as those of the other experimental children. The reader is given the impression throughout much of the book that preschool experience raises the level of functioning of mentally retarded children, until he is startled to find that the community contrast group, which began schooling at age six, did almost as well as the experimental group. This is explained on the basis of quality of home. The final conclusion, implied, seems to be that the adequacy of the home has more influence on the rate of mental growth and social adjustment than early schooling; in the case of an adequate home early schooling does not seem necessary; in an inadequate home, such schooling is essential,

or the retarded child will develop at a much slower rate.

In the case of institution children, the conclusion is drawn that six to eight hours of daily schooling and stimulation will result in early parole from the institution, with consequent saving to the individual and to the community.

Early Education of the Mentally Retarded is an important study in a field where adequate studies are not too common, and points the way to further needed research. Although it does not clearly indicate the influence of early education on later development, it does conclude that we should reconsider our belief that "a poor home or a poor mother is better than no home or no mother" for mentally retarded children.—MORRIS KRUGMAN, PH.D., New York City Board of Education.

WHY MARRIAGES GO WRONG

By James H. S. Bossard
and Eleanor Stoker Boll

New York, Ronald Press, 1958. 218 pp.

A more exact title for this readable book would be, "Why Marriages Go Wrong in the United States." At the outset, the two social scientist authors, James H. S. Bossard and Eleanor Stoker Boll, present statistics to prove that marriages do go wrong more frequently in our country than in any other country. One example from many is that approximately one half of all the divorces reported in the world each year are granted in the United States.

Why does this tragic situation exist? In order to answer this question, the authors turn a searchlight on our society. By focusing on the social factors to the exclusion of the personal factors, they have made a significant contribution, from a sociological perspective, to the better understanding of marriage failures in our culture. Their conclusions are based on various sociologi-

cal surveys and years of experience in marriage counseling.

Clearly and convincingly, they show that certain social factors in our American culture are definite hazards to marriage. Our prevailing values and standards of social behavior run counter to the fundamental principles of family life. For instance, individual development and social aggressiveness are held in high esteem while family life and family virtues are held in relatively low esteem. Our open class social system rewards individual enterprise. It is not uncommon for one member of a family to move up in the social scale, leaving other members on a lower socio-economic level. This situation is additionally complicated by the fact that national origin status also influences class level status. Above all, there is a lack of frank recognition of class status as such in the United States.

The intermingling of peoples of diverse cultures inevitably results in many mixed marriages. When young people are given free choice in mate selection, emphasis on romance tends to overshadow all other considerations. As a consequence, a married couple may have different religious beliefs, different cultural values, and different patterns of social behavior. It is these differences between peoples that causes so much friction in marriage, the authors claim; but they give little emphasis to the underlying feelings about these differences.

One of the solutions they propose is that 'like' should marry 'like'. How would such marriages be possible today, even if young people so desired, since our melting pot process has been mixing peoples of different cultures for generations? But no one would quarrel with the recommendation that Americans must give more recognition to values and value judgments, and that we should become more family-centered and less individually centered.

Although only one side of the marriage

problem in the United States is given here, it is the much needed broad sociological perspective which is overlooked by some mental hygienists and marriage counselors who have been preoccupied with the other side of the coin, the personal or intrapsychic factors. Hence, *Why Marriages Go Wrong* should be of interest to a wider public than that for whom this book was written, people directly involved in marriage.—MIRA TALBOT, Ph.D., New York City Board of Education.

ECONOMICS OF MENTAL ILLNESS

By Rashi Fein

New York, Basic Books, 1958. 164 pp.

This is a valuable book on the financial statistics of mental hospitals, and it goes beyond the intricacies of expenditures and accounting into basic questions where social policy transcends economics. The over-all annual costs of mental illness are estimated to be at least \$3 billion a year. The bulk of the direct costs derives from the cost of our mental hospitals.

It is estimated that we pay privately practicing psychiatrists a total of about \$100 million a year. A sum which is difficult to estimate, but which may be as large if not larger, is spent for that part of the services of general practitioners, internists and other physicians which goes to patients with mental illness.

The author makes the significant distinction between direct and indirect costs. The direct costs are the actual current outlays which are predominantly for hospital care and which total at least 1.7 billion. The book renders a service in pointing out the inadequacies of financial reporting by the hospitals. The indirect costs, as large or almost as large, are the lost earnings of the men and women who are income consumers while hospitalized, instead of being income

producers and tax payers. The lost earnings often extend over many years.

It is to be regretted that there is not more comment on the differences in hospital costs among the states. Even allowing for all divergences of accounting, it is well known that certain states have greatly improved the services in at least some of their mental hospitals. Something might well have been said about the comparative costs of top notch public hospitals and those of average or below-average standards.

The present expenditures for mental illness are so large that society must ask what it is getting for its money. The question could not be answered as such, says the author, without impracticable research. Can we reduce costs, he inquires, by spending less money, or by spending more money? Adding to direct costs—chiefly by increasing the psychiatrists, nurses and attendants in mental hospitals, and by ambulatory service outside—might actually save a larger sum in the indirect costs, through earlier discharges and in other ways. Mr. Fein points out the complex factors which research would have to evaluate before a reliable estimate of quantitative savings could be made, but he remarks that if we took the other tack and deliberately spent less for hospitalization now, our society would nevertheless bear the costs of mental illness in indirect and often painful ways. Humanitarian, political and economic considerations are essentially mingled in such matters.—MICHAEL M. DAVIS, Chevy Chase, Md.

MUSIK IN DER MEDIZIN BEITRAGE ZUR MUSIKTHERAPIE

By H. R. Teirich, Dr.Med.

Stuttgart, Germany, Gustav Fischer Verlag, 1958. 207 pp.

In 18 highly diversified articles and essays, this book surveys the psychological and

physiological effects of music and their applications in medicine. Only seven articles—four of which are by American authors—deal directly with methods and experimental data of music therapy as practiced in Europe and the United States. In Europe, the approach seems more cautious and sophisticated, due, no doubt, to an older, more integrated musical culture. Several authors, though contributing original studies, particularly on physiologic reactions to music, hesitate to admit the existence of a valid music therapy whose methods can be scientifically determined, or whose applications can be controlled, like the dosage of a drug.

Several articles stand out. In "Psychosomatic Thoughts about Music," Dr. Berthold Stokvis gives a concise definition of musico-somatic phenomena, and includes the results of his psycho-physiological experiments at the University of Leiden, showing psycho-galvanograms and photoplethysmograms during musical auditions, and variations due to personality structure. Dr. Wolfgang Tränkle, in a brilliant essay, "The Stimulating and Relaxing Effect of Music," describes his "electro-myographic method" which measures the effect of music on muscle-tonus and records muscle-action currents. Dr. Tränkle's thoughtful investigation includes astute observations of the socio-cultural factors which contribute to—or prevent—the success of music therapy. Dr. Rudolf Dreikurs, of Chicago, in a brief but cogent article, "Music Therapy with Psychotic Children," summarizes his methods, techniques and successes with schizophrenic and emotionally disturbed children.

From the field of the pedagogy, care and treatment of sub-normal, retarded or handicapped children, we have a report by Dr. Karl König, of the Camphill-Rudolf Steiner Schools, Aberdeenshire, Scotland.

Dr. König describes an unorthodox music therapy, based on the theories of the founder of "anthroposophy," Dr. Rudolf Steiner. Finally, Dr. H. R. Teirich, in "Music in the Framework of a Psychiatric Praxis," describes his highly individual techniques of using music in conjunction with "autogene training" and as an adjunct to group therapy and group psychotherapy. Dr. I. H. Schultz, the originator of "autogene training," also contributes an interesting article, concerned primarily with the beneficial effects of his method on the personality structure of musicians.

Music in Medicine makes valuable contributions toward a deeper understanding of the problems of music therapy, particularly in the light of European cultural conditions.—CHARLOTTE H. COHRSEN, M.D., Essex County Hospital, Cedar Grove, N. J.

A CLASSIFIED BIBLIOGRAPHY OF GERONTOLOGY AND GERIATRICS, Supplement 1, 1949-1955

By Nathan W. Shock, Ph.D.

Stanford, Cal., Stanford University Press, 1957.
525 pp.

The student or worker in the field of gerontology and geriatrics who had heretofore to engage in exhaustive research and study, has now within his reach an extensive and comprehensive bibliography, *A Classified Bibliography of Gerontology and Geriatrics*, by Dr. Nathan W. Shock.

In essaying this herculean task the author has produced a prodigious work of inestimable value. And as the field of gerontology and geriatrics widens and expands, the worth of this volume will increase in like proportion, focusing the attention of the population on the ever-increasing problems of the aging and the challenge which is ours,

to meet adequately their varying needs in the complexities of the modern world.

The vast amount of material provided by Dr. Shock has been classified and put in appropriate categories and reflects the painstaking effort and care the author has gone to in compiling this work. The volume provides over 18,000 references, also contains indices of authors and subjects, and is a valuable addition to any library. Dr. Shock is to be congratulated on the comprehensiveness of this work.—MOTHER M. BERNADETTE DE LOURDES, O. Carm., Mary Manning Walsh Home, New York.

**CRIME AND JUVENILE
DELINQUENCY, A Rational
Approach to Penal Problems**

By Sol Rubin

Published for National Probation and
Parole Association

New York, Oceana Publications, 1958. 240 pp.

Mr. Rubin's book is a mature, thoughtful and well documented discussion of problems that too often are shrouded in idiosyncratic hypotheses or clouded by emotionalism. It fully justifies its sub-title, *A Rational Approach to Penal Problems*.

The book will be of interest and value to anyone who takes an intelligent interest in the problems of modern society. For the professional criminologist and penologist, it has an unusual flavor in that it reflects the author's legal background without involving the reader in a legalistic approach.

Most of the propositions advanced are carefully reasoned and stand on their own merits.

Not everyone will agree with everything that Mr. Rubin supports. This reviewer, for example, would be inclined to give a much more negatively critical account of

the Youth Correction Authority movement. Others will doubtless find other points at which they would have preferred that Mr. Rubin support their own predilections. This makes it a worthwhile book.—F. LOVELL BIXBY, New Jersey Division of Correction and Control.

**BEHAVIOR AND PHYSIQUE:
AN INTRODUCTION TO PRACTICAL
AND APPLIED SOMATOMETRY**

By R. W. Parnell

London, Edward Arnold, Ltd., 1958, 134 pp.

Can a carefully worded, sternly objective, precisely documented scientific text on body build and body-in-action excite a modern mind habituated to critical and logical thinking—not even to mention the possibility of enthusing the heart inevitably associated in a life continuum with the same mind? The volume by R. W. Parnell on "Behavior and Physique" does exactly this to the reader. Distributed by the Williams and Wilkins Co., Baltimore, exclusive U. S. agents, this small but complex book is a must in all psychiatric and related libraries. The study invokes the shades of constitutionalists such as Pythagoras, Alcmeon, Hippocrates, and others down to the present day. It extends and strengthens the work of such modern constitutionalists as Kretschmer, Pende, Viola, Bichat, Naccarati, Draper, and Tanner. It resurrects the calipers of Davenport and widens the angles of Sheldon's fundamental photographs. It underscores the work of Rees and Eysenck and adds significance to the monumental studies of the Gluecks. In short, Parnell's studies stirred both the mind and the heart of the reviewer by the realization that the constitutionalists are on the way to long-deserved recognition as the primary organizers of psychiatric study, treat-

ment, and philosophy pertaining to organogenic orientations to human behavior. Around the constitutionalists the geneticists, biochemists, and neurophysiologists can find the focusing and channeling of their laboratory activities. Upon the work of the constitutionalists, the House of Freud, of Adler, and of Jung can find that bedrock which each of these masters proclaimed to exist and upon the assumption of which they built their mansions for all mankind.

The details of Parnell's book, their correlations, agreements, dissimilarities, etc., with those of the other workers in the vineyard are too numerous for careful review here. In fact, a commentary could be written in this direction. Thus, this brief review is largely a comment on the significance of Parnell's work. A few additional notations, however, may be made.

Like the work of the Gluecks, Parnell's approach reflects possibly the best technique available today. The documentation is impressive. New potentials for the somatotyping, or rather the phenotyping, of children are presented, and fascinating roadways have been opened for the study of family differentials as to the variety of human matings, physical dominance (husbands and wives), family size, sex ratios, etc.

More repletely than ever before, significant correlations have been derived with respect to physical prowess, traits in childhood, backward-readers, and maladjustment. The technique provides new resources with respect to the study of performance in secondary school and academic life, even to the prediction of factors affecting choice of, or suitability for, specific professional activities.

If anyone doubts that mental ill-health has little in common with constitutional factors, he should reread Sheldon and the Gluecks, and carefully study Parnell's findings. It is hoped that the ensuing hiero-

glyphic silhouettes on body-build in relation to mental ill-health will induce readers to explore Dr. Parnell's studies:

F = Fat; M = Muscle; L = Linearity; capitals indicate dominance.

Lf types: disposed to breakdown under the age of twenty-five. *Lf + Fl* (women) + *Lm* (Men) found in large proportion of younger schizophrenes. Youngest males with depressions, anxiety state, psychopathy and suicidal trends concentrate here. Stabilization tends to occur later.

Lm types: disposed to breakdown from 25 to 34 years. Paranoid schizophrenia a little more common.

MI types: disposed to breakdown 35 years and onward. Paranoid schizophrenia and primary paranoid illness commonest thought disorders. Depression major affective illness.

Mf types: most stable group. Affective disorder with depression much commoner.

F types: both men and women show diphasing. Curve of age incidence—one early in life (*Fl*), another after 40 (*Fm*). Schizophrenia occurs in *Fl* men and women, primary paranoid disorders in older people in *Fm*. Depression is common affective illness, anxiety states rare.

There is close agreement with the findings of Wittman, Sheldon, and Katz with regard to schizophrenia, especially hebephrenic forms. Paranoid features have also been found in more muscular physiques. Delinquents as studied by Sheldon, the Gluecks, Epps, and Parnell frequently may be found in the "Northwest" or *Mf* types.

The work of Parnell provides additional quarters in the expanding House of the Constitutionalists with more blueprints in the offing.—EDWARD A. HUMPHREYS, M.D., Bureau of Mental Health Services for Children, Department of Public Welfare, Harrisburg, Pa.

PSYCHOLOGICAL PROBLEMS IN MENTAL DEFICIENCY

By Seymour B. Sarason and
Thomas Gladwin

New York, Harper & Brothers, 1959, 678 pp.

Research with the mentally subnormal individual is important, Dr. Sarason says, "not only because of what we may find out about him," but also (and equally important) "because of what we may discover about ourselves and our society."

The research anthropologist, Sarason insists, as well as the psychologist, sociologist, or psychiatrist, needs to study the mentally subnormal individual in order better to understand the nature of man and culture, "not only man in the American culture, but man in the myriad cultures in which he is found." We need to know, he says, with respect to comparing an individual's behavior to certain norms, what the answers are to such questions as the following: How did psychological and cultural factors interact to produce the individual's behavior, and how representative is this constellation for the group on which the norms were based?

Part II of this book is devoted to a review of the research on psychological and cultural problems in mental subnormality. "The whole question of how much anxiety is generated in the perception by a retarded child of one test as against another has been almost completely neglected. Attention has, instead, been devoted to the appropriateness of content (e.g., verbal versus performance tests) and to a comparison of scores on tests and subtests, as though each of these scores reflected capability irrespective of differential anxiety and attitudes." The authors conclude this particular part of their discussion with the following statement: "It is certainly clear that in its

present state of development, psychological testing of retarded children contributes little either to our theoretical knowledge of the problem or to their personal dilemmas. Perhaps if we explore the emotional impact of various tests as such on retarded children this situation will improve."—W. CARSON RYAN, PH.D., University of North Carolina.

AN EXPERIMENT IN MENTAL PATIENT REHABILITATION

By Henry J. Meyer and Edgar F. Borgatta

New York, Russell Sage, 1959, 114 pp.

This project, designed to study the process of rehabilitation of the psychiatric patient according to "a controlled group design," was financed by the Russell Sage Foundation. The agency undertaking the program under study was the Altro Health and Rehabilitation Services Inc. The workshop used for the study was engaged in the manufacture of nurses' uniforms and hospital gowns which were sold on the competitive market. The research design included two groups: the first designated as "experimental" and the second "control." The study, therefore, afforded only a comparison of the group that had been in touch with Altro and others who had the ordinary experience after being discharged from the hospital.

In the selection of cases, voluntary referrals were preferred, and "authoritarian" methods of referral were discouraged. Criteria for selection were age (20–40 years), residence (the Bronx), diagnosis (dementia praecox), no previous admission to the hospital, duration of hospital residence (three to twenty-four months). The delay in transferring records from the hospital to the Altro project was a serious handicap and there was a significant loss of cases at the

screening level caused more by their unavailability than by their unsuitability. A tightening-up of procedures failed to bring the expected number of clients into the program. From October, 1955, to July, 1956, there were 39 cases screened, of which 19 were selected, and of this number only 4 entered the project. In 18 months, only 10 out of 35 of referred patients reached the workshop. Failure was explained by the late approach made to patients and by viewing the situation from a standpoint of the practitioner rather than the object of his practice. Furthermore, the experience reported suggested that the operation of agencies required study perhaps as much as the clients they sought to serve.

The study attempted was probing a most difficult and challenging area of interest, one involving some very subtle factors. One factor, for example, is the attitude of the patient toward his hospitalization. This has broad subtle implications. The admission of a person to a state hospital still has a stigma attached to it. This stigma makes itself felt most, obviously, by the person himself. Consequently, he is often—and it may be more than often—quick to sever himself from any association or connection with the mental hospital. It is clear that the coordination between the after-care clinic and Altro, specifically the interviews which constituted the referral, could impress the convalescent patient with the idea that Altro was, in effect, an extension of the painful and stigmatizing experience which the patient may have been eager to cloud in memory.

Early in this report, reference is made to transitional employment as a means of rehabilitating the patients. Later, repeated reference is made to the patients in Altro as having entered treatment. This raises some question as to whether the goals for the patient were clearly defined or whether

there prevailed an attitude which saw the persons in the project as *patients in treatment* rather than as *persons in rehabilitation*.

The reluctance of the case workers "to pursue" those persons not seeking the assistance of Altro is certainly justified. They had more experience in this kind of follow-up than the other personnel. Indeed, the study was not intended to include research on the "untested hypothesis" (mentioned on p. 29) of whether or not persons not actively seeking help can be helped. There is, actually, no clarification of the role of the after-care social workers and that of the Altro caseworkers during the period of convalescent care. Were they collaborating, or were they working in parallel, or did the after-care social workers withdraw after the referral to Altro?

The suggestion that the operations of social agencies may need study, and particularly the argument that the clientele of an agency may represent only those who get to the agency rather than the most needy, are both open to speculation regarding their pertinency. There is a teasing thought that the authors, in their frustration, may have extended themselves a bit too far in seeking to explain the lack of more positive results in the study. There are too many other factors to be investigated and clarified, such as the patient's attitude toward his hospitalization, the attitudes of the Altro personnel toward the convalescent person, the validity of limiting the Altro candidates to schizophrenics, the value of the experience of the psychiatric social workers (who do a certain amount of individual rehabilitation in their own right), and other factors which could be listed. It is suggested that much more preliminary study and research than was originally envisioned might be in order in any future study along the lines followed in this project.—MILTON E. KIRK-

PATRICK, M.D., Monmouth Medical Center,
Long Branch, N. J.

THE CHILD: DEVELOPMENT AND ADJUSTMENT

By Max L. Hutt and Robert Gwyn Gibby
Boston, Allyn and Bacon, Inc., 1959, 401 pp.

Why do babies differ in emotional responsiveness? What makes some children characteristically sad, while others are characteristically happy? Why are some pleasant, while others are hostile?

These are three of the many questions with which Hutt and Gibby introduce their comprehensive volume on child development. The authors have sought to organize their discussions around "the central unifying theme of the child's personality." It is amazing how growth occurs, they say.

"What forces are responsible for the incessant growth movement onward and upward? Why do certain stages in the child's physical and mental development occur in particular sequence? Why, despite all of the fascinating and intricate differences among human beings, are there so many fundamental constancies?"

Enough studies have now been made, they say, to make some definite statements about child development and behavior:

"All behavior is motivated; that is, all behavior is based on the underlying needs of the individual. A person is born with certain innate, biological equipment. At birth, people differ in weight, length, complexity of nervous system, color of skin, type of blood, and so on. However, they are all born with the same types of basic drives (sometimes called instincts). These original drives constitute the raw material of human nature."

What is a healthy personality? The

authors prefer a positive approach: "For our purposes we shall consider the healthy personality as that which is able to provide adequate satisfaction of an individual's basic needs, while, at the same time, enabling the individual to meet the demands of his society in a pleasurable and competent manner." And they add: "This conception of the healthy personality is a dynamic one; it assumes that personality is healthy when there is a give-and-take and a constant interaction of the individual's needs and the needs of society. The healthy and mature personality strives constantly to balance inner needs with external realities in a manner that takes both into account and finds a stable but constantly varying pattern of response."

Considerable discussion in the book is given over to the schools and their effects on children. The authors are careful to say that school will not *produce* a new personality, but it may strengthen trends that already do exist and weaken others. "Its potential influence is enormous, in the subsequent effects upon the society of which these children will be a part, as well as upon the children themselves." The authors stress particularly the "atmosphere of the school class," citing as part of the evidence the famous Iowa studies of some years back.

Special mention is made in the article of the present-day child guidance clinics with their resources for evaluating a child's needs and possibilities:

"The child-guidance clinic can evaluate a child's mental capacities, personable characteristics, special interests and aptitudes, educational achievement and disabilities, and physical and neurological deficiencies. It can offer individual and group treatment to the child or his parents as it is needed. It can act as a resource agency for general consultation and advice for school personnel. Because it is 'right on the spot,' it

can often help to prevent a relatively mild problem from becoming a more serious one."—W. CARSON RYAN, PH.D. University of North Carolina.

LOVE AND CONFLICT: NEW PATTERNS IN FAMILY LIFE

By Gibson Winter

New York, Doubleday & Co., 1958, 191 pp.

Dr. Winter addresses himself to families with growing children, to husbands and wives who have marital problems, and to families who are concerned about their older relatives.

The book is organized in eight chapters entitled: "Emergence of the New Family," "Cold War in the Family," "Father in Fact," "The Covenant of Intimacy," "A Time to Love," "Youth in Transition," "From One Generation to Another," and "Time for Intimacy."

Dr. Winter has great concern for people, and in everything he says, he is inspired by his own deep religious convictions. His professional background is that of an ordained minister and, in his pastoral work, he had become aware that he did not quite understand the thinking and feeling of the young people he was working with. This led him to the study of social sciences.

In his book, Dr. Winter describes, in a popular and understandable manner, the effects of our technological civilization on the values of our society. His thesis is that the family is uprooted and deprived of most of its influence. This he considers an evil of immense consequence. But he admits that one cannot reverse the course of a development of such scope. The turn of events leaves the family with one prominent function: to satisfy the individual's

need for intimacy. In our depersonalized civilization, intimacy cannot be found anywhere else. Yet, to maintain the functioning of the family, changes are necessary. It is at this point that the inconsistencies of the book come to the fore. The author states that we cannot turn the clock back, but that there is the necessity for leadership and authority in the family. He regrets the fact that in the American family, authority has shifted from the father to the mother and the children, but he is convinced that this will not do. The author earnestly suggests the re-instatement of the father in the position of leadership. He refers to the Bible which speaks of the authority of the husband over the wife in the marriage relationship, and he makes it clear that he believes that "the Bible provides the touchstone by which to test new developments."

Dr. Winter has read and quoted from a goodly number of the more important recent sociological books which bear on today's family situation, but he finds the answers that are satisfactory to him in the Bible. There should be no quarrel with this as long as the approach is openly declared as pastoral rather than as the integration of pastoral and sociological concepts.

Many students of family life will not go along with Dr. Winter's deep conviction that the father must be the leader and the aggressive one in the family and that the woman's role is to accept and to receive. They might be inclined to believe that in our society there is no clearly cut pattern for family life and that each family is unique and has a right to set realistic goals for itself. Each family member will work towards these goals in his own characteristic way. Leadership might change according to the particular problem a family is confronted with at any given time and, hopefully, there will be interdependence and a

certain amount of dependence among the family members.

The family has gone through many a crisis, has lived through war and peace and, so far, has been able to stand up to everything. I agree with Dr. Winter that we have good reason to believe that the family is here to stay, not because it fits our author's religious beliefs, but because the family is an inherent element of life's sociological structure.—MRS. ELSE SIEGLE, Community Service Society of New York.

CHILD-CENTERED GROUP GUIDANCE OF PARENTS

By S. R. Slavson

*New York, International Universities Press, 1958,
333 pp.*

Mr. Slavson always writes in an interesting manner, and this book is no exception. Despite all the careful distinctions made between group therapy and group guidance, group guidance is a form of group therapy.

In group guidance, "the aim is to affect specific attitudes which do not proceed from strong neurotic conflicts and compelling needs to behave in a particular manner; rather the behavior is a result of misconceptions of what the function of parenthood is, what the parent's role is in the development of the child, and of the rather universal lack of knowledge or misunderstanding of the needs of young children." Mr. Slavson discusses this in great detail and with many case illustrations. He reviews how parents learn to be parents and better understand their children; also, how family tensions are eased. Mr. Slavson carefully reviews the pitfalls when the group is led to deviate from its primary aim or when

the leader, in demeanor or by error, threatens the group's existence. In his criteria for careful selection, he emphasizes the basic requirement for inclusion of parents—that the child must not be a part of the parent's neurotic syndrome. The chapter entitled "The Dynamics of Child-Centered Group Guidance of Parents" is very interesting and well worth special study, and there is a chapter with a careful discussion of the relation of group guidance to group psychotherapy. The aim of child-centered guidance groups is not to acquire insight but rather to sensitize parents to their children and help them understand their needs.

I think Mr. Slavson is stretching a point in considering training for parenthood as essential as training for engineering or nursing.

"Empirical training on the job is the only road to skill. There is no reason why the same principle does not apply to the skills of parenthood he says."

That's a tall order, as all know who work in parent education, but it's probably because "appropriate action can be learned only through guided action which these child-centered parent groups supply." I wonder.

I'm sure that in skilled hands like Mr. Slavson's, the careful focus of the group discussions could be maintained as "guidance" rather than more formal "group therapy," and a selection of "normal and healthy parents" could be obtained. Group guidance in the hands of those not as superbly skilled as Mr. Slavson could wreak havoc, as I have repeatedly seen. This is an interesting book, and it is to be hoped that group leaders will undertake to learn thoroughly their role and the principles of group selection for guidance. This book will help them to be exacting in their functions.—JOSEPH D. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

MENTAL HEALTH AND HUMAN RELATIONS IN EDUCATION

By Louis Kaplan

New York, Harper & Brothers, 1959, 476 pp.

Schools must educate for mental health, as well as for knowledge and skills, Kaplan says in this valuable book on mental health and education.

Considerable attention is given in the book to the nature and extent of psychological disorders as a preliminary to detailed accounts of mental health programs in schools and communities. A section dealing with "environmental influences on personality" treats of psychological forces in the home, patterns of parent-child interaction, disciplinary practices in the family, and social-class influences on mental health. There is a comprehensive section on "better understanding of child behavior."

That schools have an essential function with respect to mental hygiene is stressed throughout the book. The schools must, Kaplan says, educate for mental health, "so that youngsters will learn to work together in wholesome and satisfactory ways and develop the capacity to live with themselves and with other people as mature and responsible citizens."—W. CARSON RYAN, Ph.D., University of North Carolina.

REVOLVING DOOR: A STUDY OF THE CHRONIC POLICE CASE INEBRIATE

By David J. Pittman and C. Wayne Gordon
Glencoe, Ill., The Free Press, 1958, 154 pp.

This book is remarkable, not so much for its actual content, but as an indication of the new force in the attack on such perennial American social problems as desti-

tution, alcoholism, and jails. As to its actual content, the authors, both sociologists, show that nearly one-half million Americans are caught in the vicious circle of poverty and drinking, are arrested and jailed and then released to the same chaotic social conditions which, in turn, lead to further incarceration. Hence, the term "Revolving Door." The writers demonstrate that these men fail in whatever they attempt to do, be it in school, work, or marriage. Of the greatest significance is the theme of "undersocialization," that is, the failure in their interpersonal relationships, a theme which runs through their entire lives and is probably related to their early parental deprivation.

As mentioned above, it is not the content that bears the greatest significance, for these facts have been understood for some time. The real meaning of this book lies in the authors' recommendations. Instead of jails, which they condemn as futile, they suggest the erection of therapeutic centers and halfway houses staffed by social workers, psychologists, and psychiatrists. These suggestions they consider "radical," but in recommending them, the authors represent a new force, in the sense that as social scientists, they step beyond their scientific roles into the broader and less clearly defined fields of the penologist, the politician, the judge, and the clinician. They become reformers and hence part of a wonderful and old American tradition that continually strives to improve the lot of the poor and the sick.

Yet the authors fail to convey sufficient conviction, perspective, and zeal, all of which are implied in the potent word "radical." I can hardly imagine that any legislator who reads this book will be willing to spend millions of dollars for this group of failures. Furthermore, I doubt if the writers have enough facts and experi-

ence to warrant these costly changes. While I do not disagree with their recommendations, I suggest that a great deal more experience and research from all disciplines be accrued in this complex field which extends beyond the realm of the social scientists or the clinician and into the non-scientific disciplines of history, politics, and the law. Although radical changes are sensational, those who are aware of these complexities realize that progress, to be effective, must proceed step-by-step with the pace of knowledge.—DAVID JOHN MYERSON, M.D., Brookline, Mass.

THE PSYCHODYNAMICS OF FAMILY LIFE: DIAGNOSIS AND TREATMENT OF FAMILY RELATIONSHIPS

By Nathan W. Ackerman, M.D.

New York, Basic Books, Inc., 1958, 379 pp.

This book is a plea for a larger recognition of the role of the family in mental illness. "Mental illness limited to a single member of a family group," says the writer, "is a rarity." On this account and others, he proposes the treatment of the family as a unit. This requires him to develop, in Part 1, a set of concepts for understanding family interaction, and, in Part 2, some clinical aspects of family diagnosis and some special techniques of family diagnosis. These favor the use of clinical teams and home visits. The treatment of dyads, triads, and the like require new methods intermediate between those of classical psychoanalysis (which limits interviews to the patient) and group therapy.

The underlying thesis is that sick individuals come from sick families. Even if this thesis is accepted, there are two further considerations. Sick families may come

from sick societies. And even if not, families may have connections with employers, co-workers, friends, co-religionists, and others who contribute to the mental illness of family members. The whole society is too big a unit for therapy and is more appropriately a target for reform. If the psychotherapist limits his therapy to the family, how does he deal with these "significant others," these significant outsiders who are involved in the web of family relationships? And how is family therapy to be used in our highly mobile society when the members of the family are scattered?

Students of the family will be grateful to Dr. Ackerman for increasing our awareness of the role of the family in mental illness. The question remains as to whether family therapy is superior to the traditional method of individual therapy. Perhaps each method has advantages for certain situations or under certain conditions. More knowledge is needed. The issue is one to be determined by research, not by argument, as Dr. Ackerman recognizes in his penultimate chapter.—M. F. NIMKOFF, Florida State University.

THE SOCIOLOGICAL REVIEW MONOGRAPH, NO. 1

Papers on the Teaching of Personality Development

Introduction by K. Soddy

Keele, Staffordshire, England, University College of North Staffordshire, 1958, 138 pp.

The nine papers which form this volume were originally presented at a conference on "The Problems Arising from the Teaching of Personality Development to Students of Education and Social Work" held at the University College of North Staffordshire. Although only 30 participants were expected

when the conference was planned, there were 187 registrations. The published papers suggest that the conference was well worth the interest it generated. The conference was arranged by P. Holmes. Other contributors include W. A. C. Stewart, F. E. Waldron, E. M. Oakeshott, K. M. Lewis, B. Morris, E. J. Shoben, Jr., A. H. Ilfe, and R. Wilson.

A recurrent theme in the monograph is the importance of insight into personality development for students and professional personnel in all fields dealing with human welfare. While teaching and social work receive primary attention, the discussions are equally applicable to medicine, nursing, law, and other service professions. Most of the contributors stress the importance of self-knowledge if one is successfully to achieve insight into the problems of others and attain that balance between identification which helps one to understand and appreciate the other's problem and objective detachment which makes tolerable and effective a therapist's role.

The volume reflects a psychoanalytic orientation of several of its contributors. Yet major emphasis is on the contributions of psychoanalytic theory to the understanding of behavior, and there is also a broad orientation to behavior theory with psychology depicted as playing only a part in the search for a more holistic conceptualization. Language, intelligence, learning mechanisms, culture, genetic factors are all discussed. For this reviewer, a highlight of the volume is found in E. J. Shoben, Jr.'s (pp. 102-3) neat discussion of his approach to behavior theory.

"It is highly probable that the various forms of psychoanalysis, phenomenological ideas, and reinforcement theory all possess snippets of truth, but that none has a monopoly on it. Consequently, there is a danger of real intellectual bigotry in con-

verting these theoretical systems into ideological banners and endowing them with the status of schools to be defended or positions to be fought for. They are simple tools of thought, and in our professional enterprise, the more such tools we have, the better. To argue this case is not, of course, to plead for an eclecticism that sloppily accommodates contradictions. Rather, it is to urge that the various theories be closely examined for genuine issues . . . and, . . . that they be systematically read for what they can suggest to the student about himself, his relationships, and his real or potential clients."

In general, the volume does not present new or unusual ideas, but its messages are clear and refreshing. There is also an excellent 113-item bibliography.—ROBERT STRAUS, PH.D., University of Kentucky.

PREPARATION PROGRAMS FOR GUIDANCE AND STUDENT PERSONNEL WORKERS

By Paul MacMinn and Roland G. Ross

Washington, D. C., Government Printing Office, 1959, 49 pp.

(U. S. Department of Health, Education, and Welfare, Bulletin, 1959, No. 7)

How far have we progressed in the preparation of guidance officers and other personnel workers in the schools? This is the question the authors attempt to answer.

At least 223 institutions of higher education, the authors report, have a "preparation" program at the graduate level for guidance and student personnel workers. "Counseling" is the course required by most of the institutions reporting (93 per cent), with "Analysis of the Individual" next (91 per cent). A course in "Psychological Foundations" is required in 70 per cent of the

institutions, and 17 per cent require "Sociological Foundations." At the doctoral level, "Methods of Research" is required by all the institutions, with counseling, analysis of the individual, the "practicum," and "psychological foundations" following closely.

As to personal qualifications for counseling, the authors say: "There is agreement that personal qualifications should be a factor in the admission procedure, but the difficulties involved in objective measurement make this one of the most perplexing areas to evaluate. When this factor is assessed, it is done usually through 'committee screening,' 'interview,' 'recommendations,' or methods which are identified as subjective evaluation." Two institutions, however, reported the use of the Minnesota Multiphasic Personality Inventory as a screening device for ascertaining personal qualifications.—W. CARSON RYAN, PH.D., University of North Carolina.

READING IN SOCIAL PSYCHOLOGY, Third Edition

Editorial Committee: Eleanor E. Maccoby, Theodore M. Newcomb, and Eugene L. Hartley

New York, Henry Holt & Co., 1958, 674 pp.

The third edition of *Readings in Social Psychology* is a welcome event to behavioral scientists in general and to people in the mental health professions in particular. Sixty-two articles, with topics ranging from social perception and communication to role conflict, intergroup tension and social stratification, provide the reader with an idea of the current spectrum of significant research in the broad field of social psychology.

As the three editors note in their preface, "This edition carries even further the empirical principle adopted in the two previ-

ous editions," and they "elected to concentrate heavily upon" research reports rather than on articles of more theoretical nature. This reviewer recognizes the predominance of tight experimental and quantitative studies as an integral aspect of contemporary work in the behavioral sciences. Nor is he alone in finding that the pervasive application of statistical rigor, of mathematical model construction, and the associated replacement of longitudinal and cross-sectional interview and observation methods by inventory, questionnaire and polling techniques have not been an unlimited blessing. Most observers of the social science scene agree that this has not necessarily resulted in a significant increase of basic insights in or the development of new concepts on the socio-psychological behavior of man.

In line with this present-day trend, this volume accurately reflects the rapid growth of research efforts committed to the discovery of "developmental" rather than original or unique interpretations and findings in the course of government- or foundation-sponsored study projects. Also, this volume correctly mirrors the current dominance in socio-psychological research of the "integrative" concepts of social perception and role. Whether the expanded use of these concepts, often in apparent definitional isolation from others like motive, commitment, intent, situation, and actor, will become as obsolete a conceptual style as did the notions of instinct and attitude, remains to be seen.

In the light of these impromptu reflections on the field of social psychology, this reviewer, like the editors, feels "much more satisfied about the inclusions than about the omissions in this volume." However, the articles selected for this volume are, on the whole, readable and not over-technical. They will, without question, provide valu-

able resource material and stimulating leads to all mental health professionals engaged in furthering their understanding of the normal and deviant patterns of the functioning of man as a social animal.—OTTO VON MERING, M.D., University of Pittsburgh.

THE EMOTIONAL CLIMATE OF OUR TIMES

By Bernice Milburn Moore and Harry Estill Moore

Austin, Tex., *The Hogg Foundation for Mental Health*, 1959, 11 pp.

In this comparatively small pamphlet, the Moores have put together some striking statements of unusual significance for mental health. On the one hand they describe vividly the insecurity in the world today—"knowledge that an intercontinental missile requires less than three hours to deliver in one blast more devastation than all the bombs dropped by all the planes in World War II." Ours is "the Era of the Great Doubt, often accompanied by the Great Fear." We are persons in a world afraid, "a world in which there is magnificent promise overshadowed by the peril of total destruction."

On the other hand, there is tremendous promise for man "in the concepts of configuration, of unity, of purposeness in the universe," and there are specific types of evidences for the future: "Husbands and wives, mothers and fathers, are rearing their children, developing their homes, making their decisions, and, in many instances, earning their family living as partners" and, in spite of the current popularized attack on "togetherness," a new unity and strength in the family appears to be near achievement.

Of special importance, the authors say, is the role of education today; "Education, at home in the family, at church in the congregation, and at school in the class, is being geared to the development of normal and healthy personalities." On the other hand, we have seemed reluctant to put into use what we know—particularly in the behavioral sciences:

"Even at this moment there seems to be a growing tendency to attack these same sciences and their research and clinical findings through the demand by a highly audible minority for the back-to-woodshed concept of physical punishment as the road to self-discipline; the return to fear and force as the way to control men who differ in opinions on social problems; the abandonment of education in human relations by business and industry as "too soft" an approach to problems between persons; the return of women to a subservient relationship with men through reiteration that today's women are demasculizing or even killing the men of the nation in their new roles as co-equals."—W. CARSON RYAN, PH.D., University of North Carolina.

PATIENTS, PHYSICIANS AND ILLNESS

Source book in behavioural science and medicine

E. Gartly Jaco, Ed.

Glencoe, Ill., *The Free Press*, 1958, 600 pp.

Deplorable side effects of the development of medicine as a biological science and of the brilliant discoveries in laboratory research have been a fragmentation of the patient into laboratory artifacts, and increasing specialization in the practice of

medicine, and a fragmentation in the physician-patient relationship. Countermoves aimed at restoring consideration for the total patient, i.e., the whole person with a disease rather than the disease process itself, have been the emergence of the concept of psychosomatic medicine and, more recently, the introduction of the behavioral sciences to medicine.

As the editor points out in the introduction, the contents of this book are offered as a source book of representations of the type and extent of the efforts and thoughts of behavioral scientists and medical men attempting to expand the horizons of medicine. Fifty-three of the 63 contributors are behavioral scientists, and the remainder, physicians. Of the 55 chapters, 20 have not been published previously. The chapters are grouped into seven sections each of which is preceded by a brief synoptic passage written by the editor.

A review of a book of this magnitude can obviously not do justice to the galaxy of its contributors and the wealth of their contributions. A brief summary must suffice.

The first section has been divided into two major parts of which the first deals with social epidemiology and the second with social etiology, i.e. the connection between conditions of social stress and the onset of illness. Subjects presented include the relations between socio-economic status and chronic illness.

Experimental studies indicate a significant relationship between church attendance and stress reactions affecting the cardiovascular system. The concept of "socio-somatic" illness as an extension of the psychosomatic concept is proposed.

The second section headed "Health and Community" deals with studies of those conditions to which individuals are exposed and which, in turn, bring about disease itself, such as the existence of sanitary

health practices, poor dietary habits, ignorance of preventive health techniques and practices, and laxity in obtaining proper medical treatment because of a failure to recognize symptoms of illness. It is shown that the social class of the population affected by certain diseases is a factor that very often stimulates medical research towards the controlling of that disease, that cultural biases of dietitians and nutritionists may interfere with successful introduction of nutrition programs, that the community power structure affects the outcome of community health programs and that the concepts of health and illness depend on cultural values and the social structure of American society.

The third section deals with the impact of culture upon the process of medical care and treatment and upon societal attempts at healing of a non-medical nature. Discussed are: folk and primitive medicine, some aspects of the patient-physician relationship, normative components of certain hygienic practices in a tuberculosis hospital, and the relation of changes in the American family system to some socio-cultural and social psychological aspects of illness and treatment.

The patient as "a person with an illness" is covered in the fourth section which deals with such subjects as the sick person's orientation in the hospital, differences in response to pain-experience by sub-cultural groups, management problems in Christian Scientist patients, and motivation for turning to quacks in patients suffering from cancer.

The fifth section is devoted to the social process of medical education and its impact upon the student-physician, to the various phases of development confronting the physician as he passes from his premedical training to establishing his practice, to transformations of personality characteristics of

medical students in a medical school, to differences between the clergy and the medical profession as they affect medical education, to the process of professionalization of the physician, and to medical education as a distinct social process.

"Healing Practices and Practitioners" is the heading of the sixth section. It includes chapters on: specialization in medical practice, factors that develop good doctors, factors involved in malpractice suits, the interrelationship between surgeons and their patients in a teaching hospital, the significance of the cultural environment of patients for the practicing pediatrician, the problems of the osteopath, and the consequences of socialized medicine in England.

The seventh and last section of the book concerns itself with a special realm of investigation by behavioral scientists—the medical setting: hospital, clinic, and office. Chapters in this section deal with the social structure of hospitals, hospital ideology and communication between various categories

of personnel, differentials in organization, staffing and operations between public-supported and privately-operated mental institutions, the effect of the status system of an out-patient psychiatric clinic upon patient care, and the financial aspects of medical practice.

This is an important book, very much worth reading. It suffers, as do all books of this kind, from the inevitable spottiness and lack of cohesion of different authors. At times the data presented in individual chapters become too technical for a reader not fully acquainted with the specific discipline, but even if some areas are outside the scope of a reader, rather like in a good variety show, there must be many others which appeal to his taste.

The selection presented serves its purpose of showing, in a kaleidoscopic view, representative efforts by behavioral scientists and physicians in the study of the social aspects of illness and the practice of medicine.—
E. D. WITTKOWER, M.D., McGill University.

Notes and Comments

MENTAL HEALTH MONTH ACTIVITIES

Operation Friendship, the program initiated last year to attract visitors to the nation's mental hospitals, was repeated during Mental Health Week in May. Early reports indicate that the campaign was an outstanding success. Mental health organizations across the country cooperated in this and other diverse Mental Health Month activities. The month-long Bell Ringer Campaign for Mental Health was marked by an unprecedented number of volunteers aiding in the annual fund-raising effort of the NAMH and its affiliates.

* * *

CARE AND TREATMENT

The Veterans Administration is engaging in a series of new care and treatment programs.

One such program, the "night hospital," is specifically designed for veterans in the last stage of recovery from mental illness. These veterans check into wards of VA psychiatric hospitals at the end of a day's work. They receive drugs or other treatment and the next morning receive a pass from the hospital and leave for another day at their jobs. Patients for the night hospital are carefully selected by VA medical staff members to fit the treatment to the needs of the veterans and to protect employers and the community. Only those who have shown they can accept responsibility and make good employees are chosen.

The VA has also established five "day centers" to provide a means of therapy that is intermediate between full-time hospitalization and the types of therapy available in the conventional mental hygiene clinic. A typical week's schedule at a day center includes two periods of group psychother-

apy, music therapy, games, crafts, movies, a library period, current events discussions, an open house for the patients' friends and relatives and daily conferences between patients and staff members.

A program designed to best assure aspects of individual dignity and self-respect among older, incapacitated veterans is also being conducted by the VA. Participating are the 16,000 disabled veterans who are residents of the VA's 18 domiciliary homes. The program includes psychological testing and interviewing to learn the individual's recreation and work interests. Many engage in machine shop work and clerical tasks. The new program is aimed, according to the VA, at preventing the aging veterans from "drifting aimlessly into inactivity and physical and mental degeneration."

VA Administration mental hospitals are putting the families of patients on the hospital team. At the Lexington, Ky., VA hospital, for example, there is a successful new method carried out by the patients themselves. They call it "Family Acquaintance Day." With the active encouragement of hospital officials, the 74 patients of one ward invited their families to come to Lexington and spend a whole day, seeing at first hand the life the patients lead in the hospital. The hospital reports that "the results were beyond expectations." More than 150 visitors came, a total of 50 families of patients, some traveling as far as 800 miles.

* * *

The Government of Saskatchewan has announced that it will begin the construction of a community psychiatric center at Yorkton within a few months. Since the setting up of a Psychiatric Services Branch within the Saskatchewan Department of Public Health in 1946, a series of changes have

been brought about which have drastically altered the prospects of the province's mentally ill.

The development of an active treatment program in the mental institutions has been brought about by building up a well-trained professional staff oriented to treatment and rehabilitation. In 1947 a three-year training program for psychiatric nurses was instituted; a training program for psychiatrists was also established; social service departments have now been developed in each institution.

Another area in which striking changes have taken place is in the extension of psychiatric service into the community. At present, a large proportion of the people of the province are within reach of consultation and diagnostic services in mental health and nearly half the population within reasonable reach of treatment services. The fact that all mental health services provided by the Saskatchewan government are completely free of charge to the people is an important factor in encouraging them to seek treatment promptly.

The regional psychiatric center, to be built on the grounds of the new Yorkton Union hospital and integrated with it, will have an in-patient section of 150 beds. It will also provide out-patient services, day-hospital and night-hospital care as required and community services throughout the region.

* * *

LEGISLATION

The House of Representatives has voted to appropriate \$79,863,000 for the 1961 budget of the National Institute of Mental Health. This is \$12,300,000 more than the total proposed by the President and is an increase of \$11,898,000 over the 1960 NIMH budget. The figure voted by the House includes

provisions for \$7,208,000 more for research over 1960 and \$2,650,000 more for training programs. The appropriations measure now goes to the Senate.

The increased funds voted for research include \$1,500,000 for further intensive studies in the field of psychopharmacology. Other increased research funds are designed for studies on the basic mechanisms whereby the psychoactive drugs have their effect, on metabolic studies on naturally occurring neochemical substances which influence activity of the nervous system and on fundamental neurophysiological research projects.

The increased funds in the area of training provide for continued psychiatric training of general practitioners and expanded programs of psychiatric education in the nation's medical schools. The House also provided \$5,557,000 to continue the adjustment of starting dates of training grants. Approximately \$1 million of the increased funds allotted for both training and research programs was designated for new programs and activities aimed at solving the problem of juvenile delinquency. Last year, at the request of a House committee, the NIMH took the lead in conducting a thorough study of what can and should be done in this area.

* * *

The Health and Safety Subcommittee of the House Committee on Interstate and Foreign Commerce has unanimously approved establishment of an Office of International Medical Research in the Department of Health, Education and Welfare with \$10 million authorized annually for international cooperation in health research and training.

* * *

The Senate Subcommittee on Problems of the Aged and Aging have released a report

presenting detailed findings on the needs of America's elderly citizens, with recommendations for legislative action. The Subcommittee findings are based on data compiled from evidence gathered at hearings held in Washington and in seven cities across the nation, personal visits to representative facilities for the aged, an intensive survey conducted by the Subcommittee and extensive staff studies and analyses of programs and problems.

The report deals with many problems of the aged including health status. Individuals who are mentally ill primarily because of aging constitute about one-third of the admissions to the nation's mental hospitals and about 15 per cent of the patients in these hospitals.

* * *

A report which the *New York Times* described editorially as "an important contribution to the public understanding of the farm labor problem in all of its complexities and also of the ways in which it is being dealt with" has been published. Its title is *The Position of Farm Workers in Federal and State Legislation* (New York: National Advisory Committee on Farm Labor, 112 E. 19th St., 1959).

The section on children states that "children of migrant agricultural workers suffer from all the disadvantages and disabilities that handicap the whole migrant community—unusual health hazards, inadequate food and housing due to low income level, lack of stable family life, and rejection by the community in addition, two aspects of the migrant situation particularly affect the children and their future. The first is the common use of child workers, both legally and illegally. The second is their deprivation of such educational opportunities as would enable them to make their own lives an improvement over those of their parents."

The report concludes that "legislation might be most beneficial in providing funds for schools in migrant areas that need additional facilities and trained teachers to care adequately for the children who travel with the crops."

* * *

The Medical Officer, a London journal for medical men and women in the government and municipal services, recently published some mental health statistics that its readers "may find useful when it comes to addressing the local Rotary Club or even trying to persuade a reluctant chairman of a Finance Committee to look again at the mental health budget:"

1. "If we include mental patients occupying beds in general hospitals, about 45 per cent of the staffed beds in the country [England] are allocated to the mentally sick.

2. "For every 100 patients in middle life on the general practitioner's list, about 25 consult him at least once a year with some form of mental disorder.

3. "About one in every 10 persons incapacitated for the purpose of sickness benefit on any given day are suffering from a mental disorder;

4. "Since 1951 the number of first admissions to mental hospitals has increased by 25 per cent and the number of readmissions has nearly doubled.

5. "At any given time about one per cent of people aged 65 and over are resident in a mental hospital;

6. "It can be estimated that mental illness costs the country directly or indirectly about one million pounds per day."

* * *

MEETINGS

The Sixth International Congress on Mental Health will be held at the Sorbonne in

Paris from August 30 to September 5, 1961, under the auspices of the World Federation for Mental Health. The Congress will be open to professional workers in psychiatry, psychology, education, nursing, social work and allied fields and to non-professional people interested in the promotion of good mental health and human relations throughout the world. Requests for further information should be addressed to the World Federation for Mental Health, 162 East 78th St., New York 21, N. Y.

* * *

Horizon House, Inc. (formerly Foundation House, Inc.) held its eighth annual community meeting in May in Philadelphia. Walter A. Munns, president of Smith Kline & French Laboratories, made a plea for broader state and private care for released mental patients. He said that "aftercare is today a public health problem and, as such, not only requires broader public support to finance new clinics and the necessary professional staff but also a cooperative effort by all these involved—private agencies like Horizon House, the mental health associations, the medical and pharmacy professions, the drug industry and the state legislature."

Munn received the first annual Edward A. Strecker medal on behalf of the ethical drug firm he heads. The award was presented "for outstanding service in the field of psychiatric aftercare."

Dr. Margaret Mead also addressed the annual meeting. She called for "an all-out attack on mental health problems" and urged the establishment of community clinics for early diagnosis and out-patient care.

Dr. Irvin Rutman, executive director of Horizon House, told the meeting participants that more than 600 former mental

patients had come to the center for assistance since 1953. "In the course of an average month," he said, "approximately 750 visits are made to Horizon House by about 150 former patients participating in one of our programs—social readjustment, individual counseling and vocational guidance."

A study made by the organization two years ago shows that the rate of returns to hospitals among Horizon House members was about 15 per cent, as compared to the national figure of 35 to 50 per cent.

* * *

The first national Institute on "The Total Rehabilitation of Epileptics" was held in Chicago in May. The institute was arranged by George N. Wright, Ph.D., program director of the National Epilepsy League, one of three sponsors. The others were the University of Illinois and the Office of Vocational Rehabilitation.

Dr. Wright stated that "recent study has shown that compared to other disabilities, epilepsy is the greatest block to employment. Most could become productive and valuable workers with skilled assistance from their counselors. These field workers need practical know-how in order to work effectively with epileptics and their unique job problems."

"It is our hope," he added, "that following the development of this material we will be able to conduct a series of state and regional conferences which will ultimately result in placing the rehabilitated epileptic on a payroll."

* * *

PUBLIC INFORMATION

The *Atlanta Constitution* is the winner of the 1960 Mental Health Bell Award. This award is presented each year by the NAMH

to the daily newspaper which, during the preceding year, has made an outstanding editorial contribution to the fight against mental illness.

The Atlanta newspaper last year devoted itself to an editorial examination of the conditions at Milledgeville State Hospital, stated the reforms needed and then insisted these changes be made. Jack Nelson, the reporter responsible for the Milledgeville articles, was recently awarded a Pulitzer prize for the series.

* * *

APPOINTMENTS

Dr. Oreon K. Timm, area medical director for the Veterans Administration in St. Paul, Minn., since January, 1958, has been appointed deputy to the VA assistant chief medical director for operations, Washington, D. C. He will assist in directing operations of the VA's 170 hospitals, 91 outpatient clinics, and 18 domiciliary homes. He succeeds Dr. Horace B. Cupp who is retiring after 30 years of VA medical service.

* * *

Dr. Charles H. Jones, superintendent of Northern State Hospital, Sedro Woolley, Wash., has been named superintendent of Butler Health Center, Providence, R. I.

* * *

Dr. Dale C. Cameron, a career officer of the U. S. Public Health Service from 1937-1954 and director of the Division of Medical Services, Minnesota Department of Welfare since that time, has been recommissioned in the USPHS and assigned to the National Institute of Mental Health.

Dr. Cameron has been assigned to the training branch of the Institute and, in addition, will conduct a several months' study of mental health and mental hospital

programs in a number of European countries. Later this year he will be detailed to St. Elizabeths Hospital, Washington, D. C., as assistant superintendent.

* * *

Dr. Joseph D. Teicher, director of the Child Guidance Clinic of Los Angeles, has been appointed adjunct professor of child psychiatry at the University of California School of Medicine and director of the Children's Psychiatric Services of the Los Angeles County General Hospital.

* * *

Dr. H. Martin Engle, manager of the VA Hospital in Denver, has been appointed deputy chief medical director for the VA in Washington, D. C. He succeeds Dr. Roy A. Wolford who retired in April after more than 40 years of Federal service.

* * *

GRANTS

A grant of \$1,261,448 to the Johns Hopkins Medical Institutions to establish an extensive research program into the causes of mental retardation and to aid in the construction of a Children's Medical Center has been announced by Robert F. Kennedy, president of the Joseph P. Kennedy, Jr., Foundation.

The grant provides \$1,000,000 over a period of 10 years for research into the etiology of mental retardation, including financial support of up to \$15,000 annually for each of five senior research scholars; \$150,000 toward the construction of ten beds and their related hospital facilities in the Children's Medical Center; and \$111,448 toward the construction of a laboratory floor in the Children's Medical Center to be known as the Lt. Joseph P. Kennedy, Jr.,

Laboratories for Research in Mental Retardation.

* * *

AWARDS

Judge David L. Bazelon of the U. S. Court of Appeals in Washington, D. C., is the ninth winner of the American Psychiatric Association's \$1,000 Isaac Ray Award. This award is given annually to a psychiatrist or member of the legal profession for furthering understanding between the two professions. As recipient, Judge Bazelon will deliver a series of lectures at the University of Chicago during the 1960-61 academic year under the joint auspices of that university's law and medical schools.

Judge Bazelon has become widely known in recent years for his formulation of the Durham Decision which brought to American jurisprudence the concept that when criminal acts are perpetrated as the result of mental illness, the Court will consider the nature of the illness of the accused.

* * *

President Eisenhower has presented "The President's Award for Distinguished Federal Civilian Service" to Dr. Winfred Overholser, superintendent of St. Elizabeths Hospital, Washington, D. C. This is the highest honor the country can bestow upon its career civil servants.

Dr. Overholser was commended for his "profound and far-reaching contributions in the field of mental health."

* * *

PUBLICATIONS

"Criminal psychodynamics," wrote Dr. Benjamin Karpman as he introduced the pages of a new journal in 1955, "has for its purpose the study of the genesis, development and motivation of that aspect of

human behavior that conflicts with social norms and standards."

Until that time, a journal devoted to the psychology of crime had never existed.

Since its beginning, the *Archives of Criminal Psychodynamics* has consistently encouraged research into the psychodynamics of antisocial and criminal behavior and has pioneered in the dissemination of the resulting knowledge through its multidisciplinary approach.

Since Editor Karpman emphasizes the multidisciplinary approach, other articles not directly dealing with crime are occasionally published. Moreover, philosophical and anthropological contributions, as they relate to the problem of crime, are regularly included.

* * *

The Citizens' Advisory Group of the New York State Association for Mental Health recently issued its annual report entitled "As Citizens See It."

The report includes a list of primary recommendations of the Group, as adopted by the state association, a summary of the proceedings of last spring's meeting of the Citizens' Advisory Group, and a comment on these proceedings by Dr. Paul M. Hoch, commissioner of the New York State Department of Mental Hygiene.

Copies of this report—small quantity orders only—are available free of charge from the NYSMH, 105 East 22nd Street, New York 10, N. Y.

* * *

The National Health Council has published the book *The Health of People Who Work* to offer practical help for extending occupational health services. This publication is based upon the 1959 National Health Forum and concludes the first phase of the 1959 Forum Follow-up Committee's activi-

ties. Priced at \$4.50 per copy postpaid the new book may be obtained from the National Health Council, Inc., 1790 Broadway, New York 19, N. Y.

This resource includes chapters on the goals of occupational health programs, the special problems of the smaller plant, the control of the working environment, the placement of workers in relation to their physical and mental capacities, health education in the occupational setting, preparing the worker for retirement, earning support for the occupational health program, and the placement of workers in relation to their physical and mental capacities.

* * *

The Social Legislation Information Service has issued three recent reports of interest to the mental health field:

People and Homes reports on usual and new elements in the 1960 census. Those concerned with research and public and private hospital care will need the data gathered by this census. Another report, entitled *Report to Congress on Juvenile Delinquency*, is a follow-up on the request by Congress to the National Institute of Mental Health and the Children's Bureau to express their thoughts on what should be done in this field.

The third item is an after-view of the White House Conference on Children and Youth in which so much of mental health interest was brought forward.

Each publication is priced at \$.25 (quantity prices upon request). Orders should be sent to the Social Legislation Information Service, Inc., 1346 Connecticut Avenue, N.W., Washington 6, D. C.

The Social Legislation Information Service is the one inexpensive way of keeping track of mental health and related activities and trends in Washington.

The first issue of *Rehabilitation Record*, a new 40-page, bimonthly periodical issued by the Office of Vocational Rehabilitation, contains 11 articles covering medical aspects, training of rehabilitation workers, blindness, older workers, state operations and research. The new publication will review activities of the Federal-State program of vocational rehabilitation, with special emphasis on research developments sponsored by the OVR.

In the article "Training Mentally Retarded for Employment," Fred A. Schumacher and James C. Townsell of the OVR describe 21 special demonstration workshops and analyze other Federal-State and private activities in the rehabilitation of mentally retarded young adults. The wide range of skilled, semi-skilled and unskilled occupations held by these young people whose conditions were once regarded as all but hopeless is also reported.

* * *

MISCELLANEOUS

Dr. Tom D. Spies, a physician famous as a research scientist in nutrition, died in February at the Memorial Center for Cancer and Allied Diseases in New York City. He was 57. Dr. Spies was among the first to prove that pellagra was caused by a deficient diet; he was also among the first to use nicotinic acid as an inexpensive cure for the debilitating disease. At the time of his death he was professor of nutrition and metabolism at the Northwestern University Medical School.

* * *

The integration of mental health concepts with the theory and practice of the human relations professions is the subject of a lecture program taking place between

April and November of this year. The program, sponsored by the Bank Street College of Education, is a memorial tribute to the late Dr. Ruth Kotinsky, author, educator and psychological research specialist. The lectures are being given at the Carnegie Endowment International Center, 345 East 46th St., New York 14, N. Y. Upcoming lectures will be held Saturday, September 24, Saturday, October 15, and Saturday, November 19. Time is 10:00 A.M. to 1:00 P.M. "Education" is the subject for the September lecture; "Dentistry and Nursing," the topic for October, and "Psychology and Community Psychiatry" will be discussed in November.

ARTICLES SCHEDULED FOR PUBLICATION IN COMING ISSUES OF MENTAL HYGIENE

"Some Effects of Stealing in a College Dormitory" by Paul A. Walters.

"Education's Mental Hygiene Dilemma" by Bartholomew D. Wall.

"Casework Interviewing as a Research Technique in a Study of Families of Schizophrenic Patients" by Alice R. Cornelison.

"Ethos, Existentialism and Psychotherapy" by Iago Galdston.

"Combined Individual, Joint and Group Therapy in the Treatment of Alcoholism" by Florence B. Preston.

"Transitional Programs for Psychiatric Patients" by Joseph M. Sacks.

"Controversial Issues in the Management of Drug Addiction, Legalization, Ambulatory Treatment and the British System" by David P. Ausubel.

"Suicide, Part 5" by Joseph Hirsh.

"Current Aspects of Psychiatry in Great Britain: Part 2, Recent Developments in British Mental Health Services" by H. L. Freeman and W. A. J. Farndale.

"The Main Themes of 'Existentialism' from the Viewpoint of a Psychotherapist" by Leif J. Braaten.

"Survey of Employment Experiences of Patients Discharged from Three State Mental Hospitals During the Period 1951-1953" by Samuel Grob, Simon Olshansky and Miriam Ekdahl.

"What Is a Halfway House? Functions and Types" by Brete Huseth.

"Some Observations on the Therapeutic Process in Child Psychotherapy" by J. H. Kahn.

"Psychology, Psychiatry and Mental Illness in the Mass Media: A Study of Trends, 1900-1959" by George Gerbner.

"The Extramural Volunteer" by Leon Cohen.

"Patient-led Discussion Groups in a State Hospital" by Fred Cutter.

"Criteria for Involuntary Hospitalization of Psychiatric Patients in a Public Psychiatric Hospital" by Silas L. Warner.

"The Three Worlds of the Back Ward" by Olive M. Stone.

"Recreational Preferences as Predictors of Participation in Mental Hospital Activities" by William E. Morris and Milton B. Jensen.

"Meeting the Problems of Intake in Child Guidance and Marital Counseling" by Ruth C. Oakey.

"Impact of Admission to a Mental Hospital on a Patient's Family" by Verl S. Lewis and Abraham M. Ziechner.

"An Open Service in a University Psychiatric Clinic" by Sally Dewees, Ruth F. Johnson, Saxton T. Pope and Mary A. Sarvis.

"Improving Poor Work Adjustment through Psychodiagnostic Evaluation" by Paul C. Oken and Alfred L. Brophy.

"Services Attitudes of Board and Staff Members of Community Mental Health Clinics" by Daniel N. Wiener and Allen A. Hovda.

"A Survey of Employer Reactions to Known Former Mental Patients Working in Their Firms" by Reuben J. Margolin.

"The Value of Supervision in Training Psychiatrists for Mental Health Consultation" by Beulah Parker.

"Status Stress and Role Contradictions: Emergent Professionalization in Psychiatric Hospitals" by William R. Rosengren.

"Transitional Residences for Former Mental Patients: A Survey of Halfway Houses and

- Related Rehabilitation Facilities" by Henry Wechsler.
- "Psychiatric Care in Transition" by D. G. McKerracher.
- "Love as a Measure of Man" by Benjamin Mehlman.
- "The Psychology of Democratic Freedom" by Joost A. M. Meerloo.
- "The Prevention of Mental Illness" by Donald C. Klein.
- "Mental Health and Group Dynamics for Discussion Leaders in Mental Health Programs" by Dell Lebo.
- "Hospital-patient Relationships to Medicine and Psychiatry" by Thomas S. Szasz.
- "A Survey of Vocational Rehabilitation at Longview State Hospital for 1959" by Harvey E. Wolfe.
- "The Reintegration of the Chronic Schizophrenic Patient Discharged to His Family and Community as Perceived by the Family" by Eva Deykin.
- "The Effects of an Activity Program on Chronic Psychotic Patients" by Margaret E. Hitt.
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W. A. J. FARNDAL, B.Comm., F.H.A.

Current aspects of psychiatry in Great Britain

PART 2: RECENT DEVELOPMENTS IN BRITISH MENTAL HEALTH SERVICES

"In no field of medicine have there been more marked changes than in psychiatry since the introduction of the National Health Service." This was a conclusion of the Ministry of Health in its report for 1958. It may be of interest to consider some of the more important of these recent changes, particularly in so far as they affect the trend toward treatment in the community rather than in institutions. Day hospitals, domiciliary treatment, out-patient clinics, hostels, sheltered workshops, and many other services form part of this trend. As yet, these new developments have tended to spring up piecemeal in various parts of the country and represent the advanced outposts of what it is hoped will become a comprehensive mental health service—one which does not as yet exist either in this or any other

country. In creating such a service, the experience of pioneer developments, some of which are described here, should be of great value.

PSYCHIATRIC UNITS IN GENERAL HOSPITALS

One of the most significant features of the National Health Service has been the setting up of psychiatric units in general hospitals. It is hoped that they will end the isolation both of staff and patients in psychiatry and will place mental illness on the same footing as physical illness. Such

Dr. Freeman was formerly on the staff of the Maudsley Hospital, London, and is now Senior Psychiatric Registrar at Littlemore Hospital, Oxford.

Mr. Farndale is Deputy Secretary of the Maudsley Hospital, London.

units, with up to 200 beds, have for some time existed in most general hospitals in Scandinavia (15).

In 1950, the Manchester Regional Hospital Board began a comprehensive programme, designed to shift the main responsibility for psychiatric treatment away from mental hospitals, by establishing such peripheral units—"peripheral" in the sense of being separate from the large mental hospitals which serve their areas. The activities of these units tend to be closely integrated with the life of the surrounding community, and their patients do not suffer the isolation or stigma often resulting from admission to a mental hospital. Both visiting by relatives and co-operation with general practitioners and local authority services is much easier, since general hospitals are mostly situated with a view to keeping in close contact with the community they serve. For patients who have physical complications, there is ready access to all the specialist services of a general hospital, whilst convalescent patients can easily be transferred to the status of day attendance.

On the other hand, there may be some types of treatment not available in smaller units, although this has become less likely with recent developments. Occupational and recreational facilities may not be as good as in a larger mental hospital, and it may be more difficult to handle grossly disturbed or psychopathic patients.

There may also be some overflow of general hospital routine into the psychiatric unit, which may not be helpful to the therapeutic atmosphere.

The fear has been expressed (17) that peripheral units may become clogged with chronic cases, but with adequate community services, there should be less danger of this. Experience in the Manchester region has shown that mental illness can

be comprehensively treated by local units, whose admissions have not been unduly selective. Admissions to mental hospitals from areas such as Oldham, which received the first peripheral psychiatric unit at a general hospital in the region, have shrunk to a mere trickle (9).

MENTAL HOSPITALS

The question now arises, however, of what is to happen to mental hospitals. Are they, after a burst of therapeutic activity, to sink back into being merely custodial units for chronic patients? This would seem to waste the great effort made to improve them in recent years and would ignore the fact that opinion in psychiatry has been subject to pendular swings. It is, after all, not many years since progressive British psychiatrists were advising the early admission to mental hospitals of most cases of acute psychiatric illness (5).

Mental hospitals present, in a sense, two separate problems, since, whereas the bulk of their patients at any one time are long-stay, about three-quarters of new admissions will be discharged within six months (21). There are, thus, two streams of patients: one whose composition is relatively static, and the other changing fairly rapidly. Their needs are obviously different, and it may be questioned to what extent either group is adequately treated by the mental hospital.

In this connection, the report of Garratt, Lowe and McKeown (10) on mental hospital patients from Birmingham affords valuable information. Of the 3,555 city residents who were patients, 13 per cent were considered to need full hospital facilities; 75 per cent needed limited hospital facilities (supervision for mental state or basic nursing); and 12 per cent needed none of the traditional hospital services. These were regarded as funda-

mental classes, for which separate types of accommodation were required. Long-stay ambulant patients need a hostel type of accommodation rather than the traditional ward unit which is wholly inappropriate to them. Eighty-four per cent of the patients in this sample were ambulant and would thus be suitable for "non-traditional accommodation". The third class of patients, requiring none of the usual hospital services, could be cared for in the community by local health authority services. The patients were also subdivided on the basis of whether or not they required supervision by mentally trained nurses. It was estimated that about half the patients in the first two classes and all in the third class could be dealt with by general nurses, but it was not suggested that there should be a complete separation between the treatment of short-term illnesses and the care of chronic sick and senile patients.

Several courses of action have already emerged in relation to mental hospitals. One is to cut down the number of psychiatric patients to more manageable proportions (as admissions are reduced by the work of peripheral units) and make available the empty accommodation to other specialties. For instance, chronic sick, orthopaedic, traumatic surgery, and transfusion units have moved into Lancaster Moor Hospital. This preserves the physical and administrative structure of the hospital, avoids loss of status by senior staff, and goes some way toward creating a "Balanced Hospital Community," as described by McKeown (20). The essential requirements of the comprehensive hospital are described by him as being: elimination of divisions between physically and mentally ill and older and younger patients; classification of patients according to their medical and nursing needs and

accommodation of each class in suitable buildings; a common medical and nursing staff serving all types of patients; and a more intimate relationship between hospital and community.

Another policy is described by Baker (1) as "Breaking up the Mental Hospital" and has been introduced as Banstead Hospital. Different types of patients are to be treated in a series of independent units into which the hospital has been divided. Each is to have accommodation, treatment, staffing, and activities geared to its particular type of patient. One unit will be of the hostel type for patients who cannot be discharged for social reasons, although this is regarded as properly a local authority function. Another will be for the active rehabilitation of chronic patients, concentrating on their social problems, with a view to discharge.

It is believed that an active treatment policy can avoid the development of a population of chronic patients, and that when the present hard core dies off, they will not be replaced. There are many attractive features to this scheme, but it cannot diminish the geographical separation of Banstead from the population it serves, and it may be argued that the resources required to improve the hospital in this way might be better spent on creating new psychiatric units within the area of the population. It also perpetuates the separation of psychiatric patients from others.

New detached psychiatric units have been set up containing inpatient beds, day facilities, and an outpatient department. Examples are the Halliwick Hospital in North London and Whitely Wood Hospital in Sheffield. These units differ greatly from prewar mental hospitals, being small, pleasantly decorated, and relatively informal. They are also generally more accessible and, like general hospital units,

more readily integrated with the community. They benefit, on the whole, from specialized staff, spacious grounds, and a flexibility of approach between inpatient, outpatient, and day care.

However, services designed purely to meet the needs of 1960 can readily become obsolete, and it seems likely that in the period ahead, more benefit will be gained by combining the experience of a series of parallel developments.

INDUSTRIAL THERAPY

Many mental hospitals now have "sheltered workshops" associated either with their occupational therapy department or with a rehabilitation unit. Material is usually taken in from outside firms, and patients receive a small payment for the work they do. This will generally not be of a very skilled nature, but working regular hours, and receiving any kind of remuneration can be an important form of treatment for patients who lack sufficient confidence to face the outside world again. It is being increasingly felt that a realistic work situation, at any rate as far as men are concerned, is greatly to be preferred to the "arts and crafts" type of occupational therapy.

Unfortunately, the old cry of "cheap labour" may be raised by critics of these methods, and it is usually necessary for negotiations to be carried out in advance with trade unions and other interested parties.

At Cheadle Royal Hospital (27), carnival novelties are produced, on a profit-making basis, in a small factory. Experienced workers from outside are present to work side-by-side with hospital patients and act as an encouragement to regular, productive employment.

Similar Industrial Centres have been organised by local authorities throughout

the country. They may employ mental defectives and discharged chronic psychiatric patients. There are also workshops for the physically handicapped and for the elderly, both active and infirm. In addition to outside contract work, many of these centres do valuable work for local authority departments. A factory employing only psychiatric patients has recently been opened in Bristol. It is the first experiment of its kind, aimed at rehabilitating the mentally sick. It will employ 120 patients at union rates on the assembly of ball point pens, etc., and it is hoped that the factory will become self-supporting. Initially, the patients will go to the factory from the nearest mental hospital, and, in the second stage of their rehabilitation, will be allowed to live at home or in lodgings, the final aim being for them to enter local industry as ordinary employees. Trade unions are supporting the project wholeheartedly.

The Ministry of Labour operates a number of Industrial Rehabilitation Units, where both physically handicapped and psychiatric patients go through a 12-week course. This is designed to improve confidence and physical fitness, to assess the work potential of each patient, and to lead either to immediate employment or to training for a skilled trade.

OUTPATIENT CLINICS

The origin of the outpatient service was in clinics set up by mental hospitals following the Mental Treatment Act, 1930. These were very limited in their scope, and their chief function was to decide whether or not a patient should come into hospital. Such an attitude has by no means entirely disappeared.

On the other hand, some outpatient clinics, which are designed primarily for psychotherapy, may have difficulty in dis-

posing of a patient who needs admission, because of a lack of ready access to hospital beds. It has been pointed out by Harris (15) that patients cannot be rigidly separated in terms of outpatient or inpatient treatment; all clinics should be closely associated with an inpatient unit, to which their cases can be admitted when necessary. It is also possible, in this way, to ensure continuity of care by the same staff. The other vital point is adequate staffing, both by doctors and social workers, so that patients' problems can be fully worked out in the outpatient setting.

Attendances at psychiatric outpatient departments in England and Wales more than doubled between 1950 and 1958. In all areas where psychiatric facilities are highly developed, there is great emphasis on outpatient treatment. In the case of the Oldham service, 15 clinic sessions are held weekly (for a population of 260,000), with some in the evenings or on Saturdays to avoid loss of work by patients. It is of some interest that in the first six years of this district service, the number of new outpatients rose steadily, but there has since been a definite fall, year by year.

Outpatient ECT is now a well-established feature of many clinics and is an important means of treating patients, without the necessity for admission. It has, in general, proved perfectly safe if patients return home by ambulance or in the care of relatives; the same is true of day patients. However, there are still some hospitals which do not agree to treatment being given in this way and insist on patients who receive ECT either becoming inpatients or attending for day care, believing that if a patient is ill enough to need ECT, he should be admitted.

The policy embodied in the Mental Health Act assumes that, whenever possible, treatment will be on an outpatient

(or other noninstitutional) basis. To be fully effective, however, this will require a much wider diffusion of trained personnel throughout the clinics. It would be generally agreed that the admission of patients, simply because there is insufficient time in the outpatient clinic to investigate or treat them, is a situation to be avoided. Harper (13) regards an integrated community care service as a natural development of the psychiatric outpatient clinic.

DAY HOSPITALS

The English-speaking world discovered the value of day hospitals in 1946 when two were opened almost simultaneously in London and Montreal. Both were unaware of each other's development at the time.

The original London day hospital was first known as the Social Psychotherapy Centre, and its treatment based on Adlerian principles. It was absorbed by the National Health Service in 1948 and later renamed the Marlborough Day Hospital. It is a completely independent day-unit, independence being considered valuable in avoiding the stigma of mental hospitals and their institutional attitudes (2). It treats about 1,200 cases yearly and is obliged to refer very few to mental hospitals. The director, Dr. Joshua Bierer, has stated his belief (3) that a number of similar units could largely replace the group of old mental hospitals on the outskirts of London.

For many years, a few day patients had attended mental hospitals in this country, and equivalent facilities for mental defectives, in the form of occupation centres, started in 1914. However, it was new for mental hospitals to have the equivalent of a whole ward of day patients; new for detached day hospitals to be opened away

from their parent units; and new for general hospitals to have day facilities for psychiatric or geriatric patients. In the period 1951-1953, new day hospitals were opened at Bristol, Oldham, and the Maudsley Hospital, London (14). From five day units in 1953, the number has now grown to about 70, and many more are planned or in preparation.

There are at present, two main classes of day hospitals in this country: those for mentally ill patients and those for old people and chronic sick. Some units cater exclusively to one or the other type of patient, such as the Oxford geriatric day hospital (6), but many accept both groups. In this respect, there seem to be marked local variations; several day hospitals in the London area deal predominantly with acute illnesses in younger patients, whereas the Oldham District Service has its day facilities geared primarily to the needs of senile patients. These differences may be accounted for, to some extent, by variations in population structure, availability of local services for geriatric and chronic sick patients, and the views of individuals concerned, which may be reflected in a selective admission policy.

Most psychiatric day hospitals are active treatment centres which patients may attend up to five days weekly, as required. Criteria for attendance are not uniform, but the Maudsley Day Hospital accepted the principle that day patients would otherwise have been admitted to hospital beds (14).

The Gloucester Day Centre has reported that it is used for patients who would previously have been unwilling to accept mental hospital treatment and has a valuable role to play in the rehabilitation of those who are reluctant or not sufficiently well to leave the hospital (19). This would be true of many psychiatric

day hospitals. In some units, however, the emphasis is on a short period of treatment, as an alternative to admission, whilst others are directed toward social therapy and rehabilitation.

With increasing misgivings as to the efficacy of insulin coma and leucotomy—for which admission to hospital is essential—it seems likely that more patients will be in a position to accept day treatment. In fact, the revolutionary idea is becoming established that, for a significant proportion of psychiatric patients, day hospitals are not a substitute but are actually to be preferred to outpatient or inpatient treatment.

An extension of the day hospital has been the night hospital; the first unit of this kind was again at Montreal. The Maudsley night hospital was opened in 1956 to provide accommodation for patients who no longer needed active treatment. They were seen by their doctor once weekly and could join in any of the evening activities of the hospital if they wished. In contrast, at the Marlborough Day Hospital, a night treatment centre exists to provide active treatment for patients who attend in the evenings and then sleep the night there. It would seem, then, that night hospitals tend to be of two kinds: those which are a type of "halfway house" and those designed for active treatment for patients who can only come at night, to avoid loss of work.

Psychiatric day hospitals are generally associated with mental or general hospitals although not necessarily on the same site. There have been cases where day hospitals have been unsuccessful, partly because of their situation within a mental hospital grounds and partly because of being too remote from the area where their patients live. Generally, however, patients come forward more readily for treatment in day

hospitals, as they feel there is less stigma in receiving psychiatric care when it can be combined with living at home. They are also more willing, on the whole, to complete an adequate course of treatment, and self-discharge seems to be less of a problem than with inpatients. Most psychiatric day hospitals are much more informal than the conventional hospital and tend to be run on group lines, with patients participating in the day to day running of the unit. A notable example of this approach is at the Bethlem Royal Hospital (8).

Day hospitals are, in several cases, an integral part of a community health service, and examples are to be found at Oldham and Worthing. A unit which makes valuable use of voluntary help is Stepping Stones House at Bromley (24). This combines an outpatient department, day facilities, and a social club in which patients, staff, and local volunteers meet on equal terms. The volunteers are found to be a valuable intermediary group between staff and patients, being generally closer to the patients in their social and cultural level.

Similar to day hospitals (although different in their emphasis) are day centres. These are usually organised by local authorities or voluntary bodies and provide day care, on one or more days weekly, for aged, infirm, and handicapped persons. Their facilities include occupational therapy, meals, and social activities, and some have special transport arrangements.

A research project has recently been carried out by one of the present authors (Farndale 1959-1960) under the auspices of the University of Manchester and the Nuffield Provincial Hospitals Trust. This has revealed great variety in the types of day hospitals and day centres. In fact, almost the only common feature is that pa-

tients attend during the day and return home each night.

The report (to be published by Pergamon Press, Ltd.) will show that, so far, there is very little evidence of any widespread financial saving as a result of day hospitals. Whilst their capital cost can be relatively cheap in relation to inpatient units, their treatment facilities tend to be of a high standard. The result is that running costs per patient may be equal to those of inpatients in mental hospitals. However, within the same hospital, where facilities are uniform, day patients may be expected to cost less than inpatients.

Similarly, it was found that there is little evidence as yet of a saving in psychiatric beds. Day hospitals may not only be treating patients who would not accept admission to inpatient units, but may actually be creating an additional demand for psychiatric treatment. Blacker has pointed out (4) that the apparent incidence of different conditions tends to vary in proportion to the services available to treat them.

However, day hospitals are an exciting and promising postwar development. They mark a great advance in social medicine and form an important aspect of the trend toward treatment in the community. The expenditure of extra money in this direction might bring a great return in terms of human happiness and service to the mentally ill, as well as being an economical method of achieving this object.

COMMUNITY CARE

Community care of the mentally ill has become a popular slogan, and, while lip service is generally paid to the principle, actual provision is infrequent as yet and relatively undeveloped. There are many interpretations of it, from building hostels for discharged mental hospital patients to

providing outpatient and domiciliary treatment for those living at home. On the basis of the reorientation toward community care embodied in the report of the Royal Commission, 1957, and the Mental Health Act, 1959, local health authorities have been directed by the Ministry of Health to prepare schemes for this purpose, with particular emphasis on hostels, sheltered workshops, and the provision of extra social workers. The importance of aftercare is underlined by the frequency of readmission to mental hospitals, which constituted 46 per cent of admissions in 1957.

Particular urgency now attaches to the question of the relationship between hospital and local health authority. In the past, a rather artificial distinction has tended to exist between the function of the former ("treatment") and that of the latter ("aftercare"), with one authority occasionally making up for deficiencies in the services provided by the other. It is now increasingly being realised that if "community" services were to be provided merely by local authorities and voluntary bodies, they would remain as isolated from the hospital services as before (11). Continuity of care and responsibility is the vital factor, whoever may be looking after the patient at any particular time. This may also prevent the chronic psychotic patient from being deprived of the benefit of community services.

Changes in the character of mental hospitals can have a profound influence on treatment facilities in the community outside, as well as the hospitals being influenced by these in their turn. When institutionalisation makes chronic patients unfit to return to outside life and when lack of other geriatric services forces many senile patients into the mental hospital, it is extremely difficult for such a hospital

to function as an active treatment centre. Experience at Oxford (6) has shown that a well-organised geriatric service with domiciliary and day care facilities can provide for a number of elderly patients who would otherwise have to enter the mental hospital. Macmillan (18) believes that the function of the mental hospital is not necessarily altered by community services although they may add to its resources and lessen the strain on it.

A number of important experiments in community care have been taking place in recent years, the majority based on mental hospitals. Success has been dependent, not on the acceptance of some prearranged formula, but on a high degree of co-operation between hospitals, local authorities, and general practitioners. "Each scheme can only be successful to the extent that personal relationships between individuals will allow them to work together" (7). It may be of interest to consider here some of the measures which have been found useful.

Hospital consultant psychiatrists have been given part-time appointments to local authorities, whereby they may direct the mental health services, as at Nottingham. Similarly, Medical Officers of Health have been appointed to the management committees of their local psychiatric hospitals. In some cases, staff have been appointed jointly by two authorities, e.g., an assistant psychiatrist at York, a clinical psychologist at Oldham, and social workers. Although staff may be paid entirely by one authority, they may spend much of their time working for another, by a joint-user arrangement. For instance, at Oldham, the mental health officers of the local authority are responsible for all social work in connection with psychiatric patients and come under the direction of the hospital consultant in this respect. At Middles-

borough, on the other hand, the hospital is responsible for all psychiatric social work. Hospital social workers at Nottingham operate from the mental health department of the local authority, where they are provided with office accommodation and clerical staff (Westmoreland 1959). In a number of areas, mental health officers attend hospital outpatient clinics to assist in social matters (26). They may also accompany hospital consultants on their domiciliary visits.

The joint case conference has been found to be valuable in helping to create an integrated service. On these occasions, doctors, social workers, and other officers of both hospital and local authority (sometimes with general practitioners) meet to discuss the most suitable form of care for patients in the area. They are particularly important for exchanging information at the times of admission and discharge of patients from hospital and also for keeping under review those living in the community. Before discharging a patient, the hospital staff can enquire as to the suitability of his home circumstances and the possibility of providing other adequate care in the community.

Some local authorities, such as York, are providing a Mental Health Centre to act as a headquarters for both hospital and local authority psychiatric staff, a clearing house for information and enquiries, and a centre for treatment and therapeutic social clubs. It is also useful for joint staff training and in enabling general practitioners to obtain advice and help for psychiatric problems.

Domiciliary visits by psychiatrists have been a prominent feature of most community schemes and are particularly emphasised by the Worthing and Chichester Service, which is unusual in having no formal links with local authority facilities.

In the first year of the Chichester Service, 73 per cent of the patients referred were treated by outpatient, day hospital, or domiciliary treatment (25). At Nottingham, an initial visit by the social worker is generally preferred since the preliminary investigations may take much time. The social worker may deal with problems in the home and refer the patient to an outpatient clinic if necessary.

The usefulness of extensive home visiting has been questioned by Harris: "It is extravagant in scarce doctor-time and also of money. There can only be a few patients needing prolonged specialist attention and unable to travel to hospital who would not really be better off in a hospital bed" (14). Against this must be set the much deeper awareness of a patient's real situation, which can come from seeing him in his natural surroundings and the opportunity of advising the relatives on detailed management. Leigh (16) reported that in a large series of domiciliary visits, depressive illnesses formed by far the biggest group.

The patient's home would often seem to be the place where a decision as to the most suitable form of treatment could best be made by the psychiatrist. It is also in the home that adjustment of interpersonal relationships and treatment of the family as a unit may be attempted. However, when the resources of the family and those of the supporting domiciliary and community services are exhausted, there should then be ready access to inpatient treatment.

Halfway annexes have been found valuable for the chronic patient whose behaviour does not require him to remain in the hospital, but who is unable to be discharged directly because of insufficient family and other social contacts. Mandelbrote (19) has described the value of such

units at Gloucester which ease the passage of many chronic patients to life in the community outside. It is believed that many such hostels will be provided by local authorities for psychiatric ex-patients, for the mentally subnormal, and for the elderly and infirm, who do not need regular medical or nursing care. However, not all these categories would necessarily be included in the same hostel.

During the day, the occupants of these hostels may attend a day hospital, a training centre or sheltered workshop, or go out to normal work. Training centres are provided by local health authorities and are frequently equipped for simple industrial processes. Over 300 of them exist for the mentally subnormal, but few cater as yet to psychiatric patients. The extension of such facilities, e.g. in sheltered workshops and factories, is regarded as an essential aspect of community mental care.

Community treatment has many important social advantages. Families are, as a rule, tolerant of much disturbed behaviour as long as the patient remains with them. However, once a patient has been admitted to the hospital, an attitude of rejection may develop and a closing of the family's ranks, so that his return to normal life can become extremely difficult. This is particularly likely to occur in the case of the elderly. If community treatment is possible, the patient keeps his position in the family and in society and may be able to remain at work. He is also less likely to develop an attitude of overdependence, as a result of the hospital regime, or to hand over all responsibility for his future to others. The community, on its side, must show an attitude of tolerance to those who are imperfectly adjusted to its requirements and not regard removal out of sight as the only way of dealing with aberrant behaviour. Without such toler-

ance, effective community treatment cannot be a reality.

There is, however, a limit beyond which families cannot be expected to support the disturbed behaviour of relatives, and it would obviously be pointless to leave such patients in the community if they were thereby to cause further psychiatric illness in those looking after them. In any case, the programme ahead is an enormous one, and in many areas, hospitals and local authorities will be starting almost from nothing in developing their community services.

SOCIAL WORK AND NURSING

There has always been a shortage of psychiatric social workers in this country, related partly to their training and poor salaries. In order to obtain help in the manifold problems which come within the field of social work, attempts have been made to use other categories of workers for this purpose.

The mental health officers of the local authorities have, with recent developments, been less preoccupied with their old legal and compulsive functions. In a number of areas they have been assisting in social work and, where psychiatric social workers are unobtainable, have sometimes been entirely responsible for it. This has been the case with the Oldham District Service where each officer now carries out about 1,000 home visits yearly, and the necessity for the admission of patients under legal orders has steadily diminished. The important features in this case are: firstly, practical training in case work within the service, and secondly, the concentration of all those engaged in social work under a unified direction.

Social work is also being done by mentally trained nurses, e.g. from the out-patient clinics of Warlingham Park Hos-

pital and in an active rehabilitation unit at Banstead Hospital (1). At De la Pole Hospital, a charge male nurse acts as an appointments officer for the day patients, dealing with rehabilitation and employment. In such cases, it would presumably be desirable for the nurses to undergo special training (such as that organised by the National Association for Mental Health) and to work under the supervision of a psychiatric social worker. However, it may be objected that the basic orientation of social work training is quite different from that of nursing, as are the qualities looked for in the two professions. In other words, to give a nurse social work duties does not make a social worker.

It may also be objected that, in view of the very severe shortage of trained nursing staff, it would hardly seem wise to take any out of the hospitals for this purpose. However, domiciliary and other social work would appear likely to improve the interest attached to mental nursing and might, therefore, stimulate recruiting. In some areas, nurses may be the only staff available with experience of handling patients, and may possibly be able to fill the gap in social work to some extent.

This raises other issues in connection with the role of the nurse in modern psychiatric treatment. In many psychiatric units—particularly in day hospitals—the necessity for the traditional nursing functions has been very considerably reduced. In some cases, this situation has been acknowledged, in that conventionally trained nursing staff are used only in connection with physical treatments or drugs. The rest of the nonmedical staff, which is mostly engaged in what may be described as "supportive work"—talking to patients and their relatives, arranging group activities, supervising meals and chores—consists of social or occupational therapists.

Examples of this state of affairs are the Marlborough Day Hospital and the Belmont Social Rehabilitation Unit.

We have already referred to the opinion of Garratt *et al.* (10) that much of the purely nursing work in connection with psychiatric patients could be done by general nurses. There would, therefore, seem to be an opportunity for a change of emphasis in the role of the psychiatric nurse—with development of special skills in working with groups and in supporting the individual patient. However, this question is closely bound up with the future form of the psychiatric hospital. There would be much more scope for such a nurse in a day hospital or psychiatric department of a comprehensive hospital than in a mental hospital of the traditional type. With a new role of this sort, she would perhaps no longer be regarded as the Cinderella of the profession.

The health visitor works in a related field and has special functions in connection with maternity and child welfare and with the care of sick persons in their homes. She could undoubtedly contribute much to the domiciliary work of community mental health services, particularly in so far as they affect mothers and children. Hargreaves (12) has suggested that, by supervised case work, the psychiatrist and psychiatric social worker can contribute their special knowledge to the health visitor for her role as health counselor and guide to the family. At Cardiff, there are specialised health visitors, one of whom visits cases requiring specialised psychiatric experience (22). However, as things stand at present, it would seem premature to regard the health visitor as adequately trained for social work in connection with psychiatric patients.

The position of all social workers is now in the meltingpot as the result of the

Younghusband Report (1959) which has recommended the laying down of national standards of training and status and the integration of social workers in a variety of services. With the development of the Welfare State it has become increasingly apparent that there is much fragmentation of effort in dealing with individual social problems and much overlapping of machinery and staff. The Report advises that the functions of social workers should be less specialised and that there should be three classes, each dealing with problems of a particular complexity. All three classes might work with any case requiring help, but individual social workers would have special knowledge of particular problems.

Clearly, the development of community mental care will be profoundly affected by the fate of these proposals in connection with the supply of social workers, the adequacy of their training, and the co-ordination of specialised welfare services. However, social work in mental health is also bound up with the functions of medical and nursing staff and with the character of the services in which they practise.

CONCLUSION

The new era in mental health presents formidable problems of building, training staff, and, particularly, finding the best methods for co-operation among the three branches of the National Health Service; the hospitals, local health authorities, and general practitioners. The difficulties of co-ordination are increased by the fact that the areas covered by each of the individual services are geographically different. However, Britain aims at bringing the standard of treatment of mental illness up to that of physical illness. The two are also to be merged, as far as possible, by providing psychiatric treat-

ment at general hospitals and making informal admission the rule rather than the exception. There is, fortunately, a greater public sympathy for the mentally ill and a willingness to accept them in the community, whilst still continuing treatment.

In the period ahead, new hospital and hostel building will take place, standards of accommodation and staffings raised, additional outpatient clinics, domiciliary services, day hospitals, and day centres provided, more psychiatrists, nursing staff, and psychiatric social workers trained, and more money spent on research and public relations. Treatment should thus become more effective, and mental illness bear less of a stigma. By such means, a better future is being created for the mentally afflicted in Britain.

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The extramural volunteer

When the literature on volunteer services was surveyed recently, no reference was found to the beginning and early development of volunteer activities in neuropsychiatric hospitals. The apparent absence of any recorded data on this subject is especially striking when one considers the burgeoning literature dealing with volunteer activities. In a personal communication, Helen Yast, librarian of the American Hospital Association, stated: "Though our files of literature on volunteer services are bulging, all authors seemed to have avoided the inclusion of historical information."

A concern with this question may be more than academic. If, as this author assumes, the current utilization of volunteer services in mental institutions represents, in large part, a direct application and extension of the techniques and practices that were evolved previously in general medical and surgical hospitals, taking

into account the unique attributes of the psychiatric patient could result in some different approaches to the use of volunteers. Before describing one such approach, some of the distinctions between general medical and surgical and neuropsychiatric patients that are germane to the substance of this paper will be discussed.

Of paramount importance is the fact that the GM&S patient maintains his affective ties with his family and community. Since his relationships with these agencies are presumably largely positive, the illness or injury which necessitates his separation is disruptive, and he is eager to leave the hospital to rejoin his family and friends. Rarely will the patient with healthy interpersonal relationships elect to forego these in favor of the regressive level of adjustment fostered by prolonged hospitalization.

The chronic schizophrenic, on the other hand, has not developed satisfactory relationships with others. He has not experienced, in an enduring manner, the gratification and security that interpersonal involvements are capable of providing. His

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relationships with members of his family are characterized by ambivalence, often by overt suspicion and resentment. Separation from the hospital for the chronic schizophrenic probably entails not only the return to an outside world that is still perceived as threatening and rejecting but also the severance of relationships with personnel whose warmth and interest contributed to his improvement. This way of regarding the schizophrenic's possibilities may shed some light on the slowness of his remission, his reluctance to leave the hospital, and the disturbingly high incidence of his relapse.

The neuropsychiatric patient differs from the general medical and surgical patient in another significant respect: namely, that he is usually ambulatory during his entire residence. This factor is of the greatest importance because it opens the door to his participation in therapeutic activities outside the hospital. As he experiences the external world in the company of people who are more accepting and understanding, he may learn to regard it more favorably. Relationships can develop which may expedite his remission and secure his restoration.

Thinking in this direction was stimulated by the previously reported observation that chronic schizophrenic patients tended to perform at a higher level when interacting with people outside the hospital milieu than they customarily displayed in their daily ward behavior (1). Unfortunately, these brief excursions into the community occurred all too infrequently and usually brought the patients into contact with different people on each trip. In order to increase the number of extra-hospital experiences and to provide continuity in the contacts between patients and members of the community, the idea of an *extramural volunteer* was conceived.

The purpose of this paper is to introduce the *extramural volunteer* and to describe how she has functioned with women patients at Winter VA Hospital (nervous and mental) during the 18-month period that the author was associated with the project. Mention will be made also of the measures that are currently being considered to improve the organizational structure of the program.

THE EXTRAMURAL VOLUNTEER

As is required of all members of the Veterans Administration Voluntary Service, the extramural volunteer participates in the orientation and indoctrination procedure and enjoys the privileges accorded the regular volunteers (2). However, the individual who renders her service on an extramural basis has little occasion to appear personally at the hospital. Typically, she functions within the boundaries of her own home, although she may also invite patients to activities elsewhere. Since she schedules activities at her own convenience and all arrangements are made by telephone, she needs only to call the secretary of the Female Service to make known the kind of event that is planned, the time and place it will be held, and the number of patients that may attend. Transportation is usually provided by a hospital vehicle, although patients may elect to travel in a public conveyance at their own expense. If the volunteer wishes to report or inquire about a particular patient's behavior, she can do so by telephone.

ORGANIZATION AND TRAINING OF THE CHARTER VOLUNTEER GROUP

The original volunteers were a group of young women who belonged to the same church guild. Because of its size, the guild was divided into two sub-groups which met

independently one evening a week to pursue their social welfare goals. Consistent with the general aims of the guild, but nevertheless representing a radical departure from their usual meetings, each of the groups invited a different group of women patients to a social evening in the home of one of the guild members. The author was the only male among the dozen or so guild members and an equal number of patients that attended each function.

After each social, the author remained with the guild members to answer their questions, to help clarify their feelings about the experience, and to present the concept of the role of the extramural volunteer. In the spirited discussions that ensued, many guild members remarked that they were unable to distinguish most of the patients from their own members, so well did the patients conduct themselves. The idea of functioning on an extramural basis was received very favorably, and several members of each group pledged their participation, pending endorsement of the project by the guild membership as a whole. When the entire guild voted to allow those members who wished to serve as extramural volunteers to do so, 10 appeared at the next scheduled Voluntary Services orientation and indoctrination course.

The last of the three orientation sessions was devoted to additional training for the volunteers and discussion of matters pertaining to the operation of the program. Because the volunteers felt more comfortable in group activities, they decided to schedule an evening social for a group of patients every third week. Invitations to individual patients were to grow out of the contacts established in the group socials. Prior to extending such an invitation, however, the volunteer was to get the approval of the patient's physician.

The latter was to make available to the volunteer any specific information about the patient that would be useful. As in her interactions with patients in the group setting, the volunteer was instructed to notify the physician concerning significant changes in the patient's behavior or problems that arose in the relationship. To encourage compliance with these instructions, it was pointed out that the volunteer would receive considerable reassurance and support from a discussion of her interactions with the patients.

The need for good feedback also was reinforced by reminding the volunteers that they were co-operating in a pioneer venture and that their reports would be instrumental in evaluating the program. This emphasis probably served to heighten their motivation as well as to imply that categorical answers were lacking to many questions they might raise. To one of these—how the volunteer ought to relate herself to the patient—it was suggested that, in general, accepting the patient as a worthy individual and reacting with warmth and spontaneity might promote the kind of friendly relationship that would be helpful.

As supplementary training, the author revealed that he planned to attend a number of the evening activities and would be available for discussion following the patients' departure. The volunteers were told that the chronic schizophrenic patients selected for participation were members of the same occupational therapy group and were receiving group psychotherapy. Knowledge of the patients' reactions to the socials, obtained in the group meetings, would be used to alter the program as the situation warranted it. To be sure, it was pointed out that any suggested changes would not be implemented without the volunteers' approval.

The author's decision to be present at several socials also was motivated by the desire to expedite the smooth operation of the program and to allay the volunteers' anxieties. Concerning the latter, the volunteers were informed that the patients would be screened to exclude those that might create a disturbance and that, as an added precaution, hospital attendants would be present at the group socials.

Anticipating the next section in which the extramural program will be described, it may be stated now that there has not been a single instance of untoward behavior by a patient. This has been the case regardless of the number of patients and volunteers participating in the particular activity, and despite the fact that the patients were unescorted by attendants after the third social. With the full consent of the volunteers, the attendants were withdrawn when the patients complained in a group therapy session that the attendants' presence reminded them of their patient status and that this interfered with their enjoyment of the activity.

DESCRIPTION OF THE EXTRAMURAL PROGRAM

The success of the first social which launched the extramural program was verbalized by the volunteers in the discussion which followed and confirmed by the patients when they convened for the next group therapy session. However, it became very clear in this therapy meeting, as in every other one which followed a group social, that the extramural activities raised a considerable amount of tension in the patients (3). After the patients had attended about six such functions, they indicated that they would not care to accept any more group invitations.

Because avoiding participation in the extramural program was viewed as a form

of resistance, the staff was of the opinion that the activity should be placed on a prescription basis. This did not occur for two reasons. First, the patients now were highly involved in the discussion of important personal material. Second, the volunteers opposed the idea on the grounds that they would not feel comfortable if the patients were compelled to attend the socials. This was the determining factor in abandoning the prescription proposal.

It was decided to make the extramural activities available to another occupational therapy group, but when a similar sequence of events took place, the program was opened to all schizophrenic patients on the Womens' Service who were able to attend extramural activities. A roster was drawn up of those patients who were considered to be most in need of the socializing experience, and these were solicited first when a group social was in the offing. Among the group, frequently, were patients whose presence was specifically requested by some of the volunteers. During the first nine months that the program operated in this fashion, patients did not have the opportunity to discuss their reactions to the extramural activities in a group setting. Nevertheless, there is reason to believe that many patients profited from merely attending the activities.

The volunteers have provided the patients with a broad range of activities. Regarding the socials: these have occurred during the day and evening and were arranged for small and large groups of patients. Parties in celebration of a particular holiday typically were planned for about 20 patients, whereas about half that number usually were invited to the ordinary social. Groups of about 10 patients generally were requested for such daytime activities as the mid-morning coffee or the afternoon card party.

Frequently, the volunteers, singly or in pairs, invited individual patients, alone or in small groups, to spend part of the day with them. On these occasions, the patient might accompany the volunteer and her family on a picnic, join her on a shopping trip, or, as was more often the case, simply visit with the volunteer in her home. In the latter circumstances, she might socialize with the volunteer as she continued her sewing or knitting, acquire some useful skills, if the volunteer had such to communicate, or help the volunteer with some of her routine household chores, if she were so inclined. It is interesting to note that the spontaneous offering of assistance increased as individual patients began to visit the volunteers more regularly and to take cognizance of the social amenities.

The last large group activity prior to the suspension of the program during the summer months was the picnic barbecue. Twice now the patients have selected this activity as the one in which they might exhibit their gratitude to the volunteers. To the complete satisfaction of the volunteers and staff, the patients have been able to accomplish this by contributing to the cost of the barbecue, assuming responsibility for planning the menu, purchasing and preparing the food, and seeing to it that their guests had an enjoyable evening. Needless to say, the bill of fare at the barbecue was much more sumptuous than it was at any of the volunteer-sponsored social events.

It was stated previously that the communication of information concerning patients' behavior at these various activities was handled chiefly by telephone. In addition to this informal procedure, from time to time the author joined the patients at an evening social and usually was apprised of patients' progress in the discussion which followed the entertainment.

These two techniques proved very satisfactory during the initial 18 months of the program.

Recent changes, however, have made clear the need to tighten the organizational structure in order to improve communications between the volunteers and hospital staff. As the program expands, new volunteers are being inducted. New staff members have been assigned to the program and have brought to it added insights. Furthermore, the frequency of spontaneous communications by the pioneer voluntary group has diminished, presumably because the novelty of the program has worn off.

Two methods are being considered to ensure the constant flow of information. In the first of these, the one which would make minimal extra demands on the volunteers' time, the hostess for the occasion would be given the responsibility of collecting the impressions and observations of the other volunteers attending the event. These would be reported to the hospital staff member who called her the next day. Since the volunteers take turns serving as hostesses, they would share equally this data-gathering and reporting function.

The second method calls for a regular monthly meeting between the staff and volunteers who interacted with patients during the month. Although such a meeting would alter the strictly extramural aspects of the program, it would be the most thorough and potentially the most effective approach to the problem. The plan is to try the first method, and if it is found to be lacking, the monthly group meeting will be added.

DISCUSSION AND IMPLICATIONS

In suggesting that volunteers can make a valuable contribution by interacting with patients in the extra-hospital environment,

it is not intended that extramural functioning should replace the traditional intra-institutional activities of volunteers, or that the former should be carried on at the expense of the latter. Rather, the author is in full agreement with Dr. Daniel Blain, Medical Director of the American Psychiatric Association, when he stated:

"... that mentally ill patients in all the categories need not only special techniques of diagnosis, treatment, and rehabilitation which can only be given by those specially trained; but also they need, in equal and perhaps far greater amounts, the application of social forces to assist them to regain their own individual strength and abilities to become resocialized and recultivated, and to benefit maximally from the technical treatment procedures which they are given (4)."

An extramural program can mobilize more of the constructive social forces to which Dr. Blain alludes. Inasmuch as it attempts to reach those members of the community who are unable to volunteer their services for a variety of reasons, an extramural program can markedly increase the hospital volunteer corps. For a large segment of the population there are many obligations and duties within the home which require constant attention. Young housewives, for example, may have the care of young children as well as their homes to consider and would have to incur an expense for baby sitters, besides transportation costs to and from the hospital if they choose to serve as volunteers. In addition to these factors, which probably are prohibitive for many potential volunteers, there is the matter of regular attendance desired of the traditional volunteer which many individuals in the circumstances just described feel incapable of achieving. It

is for reasons such as these that people respond favorably to the idea of serving on an extramural basis where the patient comes to the volunteer's home and at a time convenient to her.

As the size of the extramural volunteer corps expands, more people develop a better understanding and appreciation of the emotionally ill patient. Distorted conceptions of the mentally ill are altered significantly as a result of the face to face experiences in the extramural setting. And while it has not occurred thus far, it is not inconceivable that some volunteers may make their homes available as foster homes and that an actual placement may grow out of a particular patient-volunteer relationship.

Besides having a pronounced catalytic effect on patients' involvement in other therapeutic activities, relationships with volunteers have developed which materially influenced some patients' hospital course. As they interacted with friendly and understanding individuals from the extramural community, patients have been prompted to forego their dependence on the hospital for protection and security. The emotional gratification derived from the relationships and their acceptance into the volunteers' homes apparently fostered the realization that the external world was not populated by alien and rejecting people. Because these patients continued to visit the volunteers following their separation from the hospital, the extramural relationship not only was the patient's link to the outside, but also her stable anchorage in it when she took her place in society.

Turning now to some implications of extramural functioning, although our experiences for the most part have been very encouraging and in a few instances quite dramatic, research is needed to provide answers to the many questions that the

extramural concept raises. Immediately, one must wonder about the applicability to a male schizophrenic population. Would the same total absence of untoward incidents characterize the relationships of male patients and female volunteers as has been the case with our women patients? Would female members of the community be as ready to volunteer their services on an extramural basis if they were asked to invite male patients into their homes? Would the program be as effective if the male patients interacted with male volunteers, and how many of these could be enlisted to devote an evening or part of a week end to patients? These are but a few of the issues that must be settled before the proposals to be described can be enacted.

Assuming, for the moment, that the evidence from controlled studies corroborates our belief in the value of the extramural concept and demonstrates that it can be extended to a male population, it then could be incorporated into a hospital rehabilitation program. Early in the patient's hospitalization, perhaps when he is being presented for diagnosis and appraisal, the role that extramural activities are to play in his rehabilitation would be considered. Thought would be given to the appropriate time for individual contacts to begin, the frequency with which they ought to occur, and whether relationships with one or more volunteers should be encouraged.

Patients who are unable to tolerate an excessive amount of social interaction and, hence, cannot attend the social event, might be involved in an extramural project, an activity which is more task-oriented. These projects would occur in the volunteer's home and would be available to small groups of patients. The nature and variety of the projects would be contingent upon

the particular talents or skills of the volunteers and the facilities they have at their disposal. An activity of this type, an extramural cooking class that was to meet once a week, was arranged for six women patients, but the untimely illness of the volunteer necessitated its postponement. In this activity, the patients were to participate in every phase of the operations entailed in the preparation of a number of different recipes. Provisions for habit-training also were included in that the patients were to be taught how to conduct themselves at the dinner table and how to clean the kitchen articles they had used after they had eaten. The patients were to convene for a group meeting when they returned to the hospital following each class.

As the patient's rehabilitation proceeded to the point where his discharge was being contemplated, cognizance would be taken of the relationship he had formed with any of the volunteers and the extent to which these relationships could be utilized to secure his extramural adjustment. Often, however, patients return to communities which are quite far removed from the hospital. As a result, relationships with people who have been instrumental in their recovery process usually are terminated, and the patients again may feel isolated and helpless in a hostile environment. To bridge the gap between hospital and community and thereby facilitate the restoration of these patients, extramural volunteer groups could be organized in the outlying areas. Distance from the hospital would preclude service as a traditional volunteer but only would limit extramural functioning.

As part of the discharge planning, the advisability of continued extramural contacts would be discussed with the patient. If he agreed that they would help him to

readjust to extra-hospital living, a volunteer group would be notified by mail of his pending separation. To pave the way for the new relationship, the letter also would mention briefly the kinds of extramural activities he participated in during his hospital residency.

Thus far, the extramural concept has been discussed as it might be applied in the rehabilitation of schizophrenic patients. That it might have important application with ambulatory geriatric patients was suggested by an elderly church woman who just had been acquainted with the extramural program as it has been operating with female patients and volunteers. After pledging her enthusiastic support for the program, she wondered whether there was anything for males that was comparable to it. She proceeded to explain that her husband had been retired for some time and had been unable to gainfully utilize his time. She felt certain that he would derive enormous personal satisfaction from helping some elderly patients.

It may be that the extension of the extramural concept to the ambulatory aged patient will enable the forcibly retired individual to feel that his services are still needed and that he is still capable of making an important contribution. This benefit would be over and above the possibly significant impact the program may have on the patients.

Finally, it is apparent that the successful development and execution of such a

complex program would require a great deal of co-ordination and integration. Since it would be quite premature to conjecture about the many facets of the program where this would be necessary, it will suffice at this time to merely underscore the need.

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JOSEPH HIRSH

Help for the living, hope for the dead—Robert Green Ingersoll: "Address at a Little Boy's Grave."

Suicide

PART 5: THE TROUBLE SHOOTING CLINIC: PROTOTYPE OF A COMPREHENSIVE COMMUNITY EMERGENCY SERVICE

Every year to the 60,000 estimated successful suicides and the 300,000 unsuccessful attempts must be added the tens of thousands of alcoholics who fall off the wagon and into an alcoholic vortex, dragging countless thousands more down with them. To these everyday everywhere must still be added all sorts of human crises in response to a variety of stress situations—about parents and parents-in-law, about marriage, separations and divorces, about sudden death in the family, about illness and accidents—which go to make up the hundreds of thousands of people who annually become the potential objects of violence, often ending in injury, disability, or death.

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What do these people have in common?

First, they need help, often urgently. Second, with the disappearance of the family physician from the American scene—the traditional fount of counsel and advice—they don't know where to turn for help, the central ingredient of which is an opportunity to talk to someone. These people are virtually all in need of emotional first aid, first aid which is not and cannot be given in the overburdened and overcrowded emergency rooms and mental hygiene clinics of our hospitals. Many of them are also in need of acute or long-term medical care. Where such assistance has been made available, catastrophe has often been averted temporarily, at the very least, or prevented entirely.

For those beyond this precrisis stage, who may be actually in patent psychologic or physical distress, there is the need for medical trouble shooting resources to mitigate the seriousness of distress, permanent

disability, disfigurement, or death. The child who has just been rescued after having been accidentally locked in a deep freeze, the infant who has swallowed a cosmetic preparation whose formula does not appear on the label, the elderly parent barricaded in the bathroom threatening to swallow some pills in the medicine cabinet—all are candidates for medical rescue. To be sure, they may be in need immediately of police or fire department rescue squads but without concurrent medical assistance or guidance, the largely mechanical efforts of these other important resources often may prove to be ineffective.

Under the most optimistic conditions, private practitioners in medicine or psychiatry can only hope to deal with a fraction of these problems. As a consequence, a variety of specialized medical and paramedical groups, agencies, and clinics have emerged in recent years to cope with these near-tragedies or their consequences.

Alcoholics Anonymous, which has served as a model for other not-quite-so-successful organizations such as Gamblers Anonymous and Addicts Anonymous, is also serving as the prototype for suicides. The Suicide Bureaus of the Salvation Army are other examples. In recent years, other medical and hospital-oriented organizations have been set up, such as Rescue, Inc. in Boston City Hospital and the Coma Center at Flower and Fifth Avenue Hospitals of the New York Medical College.

Stimulated by such groups, state and local health agencies have entered the field of suicide and poison control with the development of specialized centers which generally perform one or more of three functions. One of these is research involving demographic and epidemiologic studies of suicides and accidental poisonings, the findings of which are made available to physicians and others in the community.

The second function is the provision of information and educational materials to the public-at-large. The third is primarily an advisory function dealing with problems of patient management and control as well as referral of patients and their families to specialized agencies for long-term care and treatment.

Since poisons represent a very special problem in both accidents and suicides, it is not surprising to discover that only since 1953, well over 300 Poison Control Centers in some 45 states have been set up throughout the country. These are under the sponsorship of health departments, medical schools, hospitals, and local medical societies.

These centers, most of which have around-the-clock telephone service, furnish to physicians information on the identification and toxicity of ingredients in trade name and commercial products of all kinds as well as the most current methods of treatment for various kinds of poisoning. For the nonmedical person calling these centers for help, emergency first-aid instructions are given. Since 90 per cent of these centers are located in hospitals, they are capable of providing, and indeed do provide, specialized treatment services. Other nonhospital centers furnish information and referral services only.

Suicide is only one of the many forms of violence which, when viewed as a process, may be interrupted by such specialized centers at various points before it becomes a final act. These centers have already proved their worth many times over in demonstrating what can be done to prevent such catastrophies. But special clinics and facilities which are set up to meet each particular kind of human problem and tragedy are useful, primarily, in calling attention to the problem and demonstrating what the resources of institutional

medicine can do constructively in dealing with it.

A more basic long-range attack can be made through an integrated effort in emergency service care, a prototype of which was started at the Elmhurst General Hospital in New York City in 1958.

Elmhurst General Hospital, one of the Municipal General Hospitals in the New York City system, is located in an area of middle-class private homes and middle-to-lower middle-class apartment houses in the Borough of Queens. It has a capacity of 970 beds and 170 bassinets. Its primary function is to render medical care to those in need and often unable to pay for it. Yet, above and beyond this call is a "Trouble Shooting Clinic" which distinguishes this hospital from its sisters in the City.

This clinic has no special entrance, no outward distinction from any other clinic. One enters it through the main portals of the hospital. The directory simply lists it as one of several clinics. An arrowed sign or the guard on duty points the way to the clinic. Unqueued, less harried and less flustered than most City hospital clinics, the Trouble Shooting Clinic has a receptionist sitting outside of an anteroom which serves as a general waiting room. Generally, the receptionist is quietly involved in an in-take interview, referring a patient in the anteroom to a specific physician or social worker. If more than one patient is at the receptionist's desk and obviously in need of immediate attention—marked by anxiety, agitation, extreme tension, or volubility—a social worker or physician may be called immediately to take care of the "overflow."

The treatment rooms, as in most of the City's modern hospital mental hygiene clinics, are directly off double corridors to assure uninterrupted quiet.

The history of the Elmhurst General Hospital Trouble Shooting Clinic is of recent origin. It was established in November, 1958, and is the brain child of Dr. Leopold Bellak, director of psychiatry at the hospital. Originally open only one evening a week, as soon as word of its existence spread throughout the community, it had to open two more evenings. The clinic is eventually expected to function 24 hours a day, seven days a week.

The Trouble Shooting Clinic is part of the hospital's Comprehensive Community Psychiatric Program which includes seminars for those leaders in the community who are most likely to come in constant contact with candidates for the clinic. These include general practitioners, chaplains, lawyers, and law enforcement officers.

The Trouble Shooting Clinic at Elmhurst General Hospital is a "walk-in" clinic. Coleman and Zwerling have pointed up the need for such emergency clinics, based upon the experience with regular mental hygiene clinics which, soon after establishment, are overwhelmed. As a consequence, they lose "any ability to deal with the earliest manifestations of mental illness at a time when we probably can be most helpful, i.e., during the crisis situation before the psychiatric illness has been incorporated deeply into the personality" (1).

Within the framework of a medical school teaching center and its intern and resident training programs, it is entirely feasible to run such emergency services on a 24-hour basis. This is not possible, as a rule, in other general hospitals, as the Elmhurst experience in its present form attests. But in its future projection it becomes as practicable, as in the case of our teaching center (2).

At Elmhurst General's Trouble Shooting Clinic there is no conventional screen-

ing of patients before appointments are made. Nor is referral by family physician, police authority, or anyone else necessary. All one has to do knowing that there is such a place is to walk in and talk things over. Thus, this clinic has become the battalion-aid station, the first echelon of medical care, for people with bruised feelings and emotional upsets as well as more serious psychological complaints. Usually it takes little more than one interview (typically this lasts 45 minutes) for the trouble to be thwarted or to be solved. It seldom takes more than three visits. If it does, then second or third echelon care is indicated, such as other specialized clinics or inpatient care in the hospital or specialized legal, welfare, or counseling agencies, if the problem is basically nonmedical in nature.

The "walk-in" clinic differs from the Mental Hygiene Clinic or even the 24-hour psychiatric coverage of the emergency room of a general hospital in that it is designed to care for emergency emotional problems immediately, on the spot. It is not structured, staffed, or equipped to deal with these problems on a long-range basis. Presently its staff consists of three psychiatrists, two psychologists, and four psychiatric social workers, capable of dealing with psychiatric crises but equally knowledgeable in community service resources which so often must be made available to many of the patients coming to this clinic of crises.

To date the Elmhurst experience, with some 1,200 cases treated, justifies the view that such clinics have a real place in every hospital which views itself as a community service center in the area of health. Yet precisely what kind of cases can such a clinic handle?

Ninety per cent of the self-referred patients coming to the clinic as a result of

local publicity or of word-of-mouth communication have been found to be suitable for treatment in the trouble shooting service. The occasional psychotic who shows up is generally referred to the inpatient service and of the total number of patients coming to the trouble shooting service, fully 85 per cent are in need of the care capable of being rendered by this clinic. Fifteen per cent require either referrals to social agencies, limited pay clinics, legal aid agencies, and direct medical rather than psychiatric service. Of the 85 per cent hard core group, a large number require medical in addition to psychiatric care.

Although this clinic is run in a municipal hospital, partial support comes from those patients able to pay for care. This has been estimated at approximately \$3.00 per one-half hour of patient visits and goes to pay for the cost of professional help only. The City's contribution consists of the plant, utilities, and clerical personnel.

Who comes to such a clinic? Chiefly people who may be described as having situational neuroses, such as the following:

A.B.R., mother of five, lives with four of her children, husband, and mother-in-law in a small converted summer bungalow. Mr. B.P.R., a former service career man, now earns a good salary as a stationary engineer. Mrs. R., a worn, tired-looking woman, came to T. S. Clinic because she "was at the end of my rope." For years she has wanted to move—this year the tide flooded her basement kitchen six times, necessitating her cooking with rubbers on—but her husband objected for one reason or another. Mrs. R. admitted that she has always kept silent to keep the peace, but now she doesn't know what to do. The cramped quarters were the source of many tensions in the home and reflected the poor emotional adjustment of two of her children.

Mrs. R. was encouraged to be more aggressive in her demands and face her husband with her feelings. How she would present it was gone over in the first interview. The follow-

ing week saw a smiling, happier woman who had faced her husband with her feelings to find he was more amenable than she thought. In fact, between visits they had looked at other homes, and she saw one that she liked. She enthusiastically talked of future plans and commented how the whole family has responded to her change in mood. She will be seen in a few more weeks as part of follow-up.

G.R.K., a very attractive nineteen-year-old girl, came to T. S. Clinic with an inexplicable depression which, upon further investigation, was seen to have begun with her sister's marriage and boy friend's proposal. In two interviews her attitudes toward marriage—woman, a drudge after marriage; man, always happy—were explored with the goal of relieving her anxiety by making her aware of her envy of man. The gradual recognition of these feelings has seen a lessening of the depression, and patient is now prepared to accept longer-term therapy.

D.L.M., a twenty-two-year-old Negro, came to T. S. Clinic because of his "sloppy eating habits." Further examination revealed that his tic-like condition was present for almost four years but exacerbated since his marriage of over a year. Wife, now four and one-half months pregnant, was seen as a woman who constantly demeaned and berated patient and who is unable to cope with his frequent mood swings. History showed that Mr. M., who never knew his own parents, was one of seven foster children. He married his wife after learning she had had an O.W. child by another man. He expected her to take this child into their home after marriage. To date, she has refused.

Because of the pathological basis for the marriage, as well as patient's emotional investment in it and unlikelihood of separation (wife expecting), no attempt was made to uncover dynamics. Instead, he was supported and encouraged to be more assertive with his wife as well as given direct advice on what subjects to take at night college where he has been doing failing work. After two interviews, patient called to cancel third and reported that things were better at home. Wife may be seen if

patient tells her of T. S. Clinic contact, to which she was vehemently objecting.

A fifty-one-year-old woman, mother of a seventeen-year-old son, separated one year from her husband, referred herself to our clinic after reading the *Coronet* article.¹ She had no specific complaints and had little idea of what she might expect from our service, but it soon became apparent that she was living an aimless and lonely existence and was subject to periodic depressive sensations. She left her husband after years of smoldering tension and was especially hurt by the son's decision to remain with the father. During this year, increasing guilt troubled her because she felt she had abandoned her son, and she could not return to the husband's house lest she "lose face" in admitting she might have made a mistake. She tried in vain to keep up some kind of relationship with the son by telephoning him, buying him gifts, etc., but was openly rejected by the son, who had adopted the father's attitudes toward the patient. The more she tried to get closer to the son, the more openly he rebuffed her.

In our discussion it became clearer to her that she was playing a self-punitive role and was inviting rejection, which fed her self-pitying feelings. While still unable to reach a decision as to what she wanted to do about her marriage, she gradually accepted the importance of herself as an individual and the importance of concentrating on her job, developing gratifying social contacts, and in various ways fostering her self-worth. Thus, she was able to communicate more comfortably with her husband whose more positive attitudes toward her paved the way for the son's acceptance of her. She is now entertaining the possibility of rejoining her husband, who is becoming more receptive to marital counseling or other professional help for this divided family.

A twenty-one-year-old single young man, a recent college graduate, was brought in by his mother against his wishes after she learned about the T. S. Clinic through a local newspaper report. The son had started to work for his Master's degree at an out-of-town university but dropped out after several weeks for two reasons, primarily: (1) lack of a definite vocational objective and (2) marked dependency needs which were aggravated by separation from the family and heightened his anxiety.

¹ Irwin, Theodore, "First Aid for the Unhappy," *Coronet*, 47(January 1960), 123-27.

His initial resistance to professional help soon gave way to recognizing that the clinic was sincerely interested in helping him and that his abilities and personal happiness required finding definite and practical professional goals. To implement this, he accepted referral to the New York State Vocational Advisory Service for aptitude studies; he also accepted the advisability of psychotherapeutic help, for which he was willing to pay from his own earning. Thus, a self-defacing and dependent individual took definite steps to self-help and mature behavior. At the same time, while residing at home, he planned to register at a local university for graduate courses.

Voluntary general hospitals, particularly in smaller communities, are "naturals" for developing trouble shooting clinics to deal with cases such as these. But these hospitals, acting as community service centers in the area of health, even more than those in larger cities, are in a position to develop such clinics on a broader, integrated base.

In concept, an integrated emergency service must be something more than an expanded, departmentalized, highly efficient emergency room. It is much more than such an outsize room could ever hope to be because of its philosophy, functional orientation, administrative relationships, and staff.

What then is the underlying philosophy of such a clinic? First, it is one of rendering emergency service in *whatever problem area* is presented by anyone who may become, or is, a patient as a consequence of a stress situation, accident, disease, or trauma. Emergency service is not to be confused with *minimum* or patchwork care which is often the most that emergency rooms are geared to give. It means *maximum* care in the solution of present problems. Second, such a clinic is concerned with securing more than immediate gains. This can be achieved through appropriate referral and follow-up as soon as the immediate problem has been dealt with.

All sorts of *prepatients* might be expected to use profitably the services of such a clinic: the presuicidal, the dry alcoholic about to go off the wagon, the rehabilitated drug addict in a state of acute tension, the acutely depressed, the unusually tense teen-ager, the accident-prone, acutely upset or distressed, the married couple severely traumatized by strife and about to become police action cases, the individual who has accidentally ingested an unknown toxic material, and countless more.

The clinic has many patient functions to perform. It is capable of serving as a *combination* battalion aid and clearing station, rendering emergency medical and surgical care and triage for the inservices and specialized long-term clinics of the hospital as well as other community health, welfare, and educational agencies. It would serve as a walk-in, emotional first-aid station for people in need of a sympathetic and sensitive ear, a shoulder to cry on, or some practical advice. It could render emergency advice or assistance by telephone to people in distress. It could serve as an information and advisory service to physicians and public agencies, such as police and fire department personnel, in dealing with all sorts of acute emergencies and rescue operations.

The clinic could be something more than a necessary service through which medical students and interns were required to rotate as part of their training experience. Because of the richness of its material and the diversification and intensity of its problems, this clinic could become one of the most important teaching resources for many students and disciples outside of medicine proper—social workers, psychologists, students in the ministry, welfare and guidance people, law students, and law enforcement personnel.

The administrative structure of the clinic must be such as to ensure its various functions. To assure continuity of service, it should be staffed on a 24-hour basis. It should have a sufficient number of telephone extensions connected with the hospital switchboard as well as direct lines which are independently numbered and well-publicized throughout the community served by the hospital.

As the first echelon of medical service, the clinic should be centrally located in the hospital compound to facilitate the movement and referral of triaged patients to other clinics and services. It should be easily accessible to the outside public and its facade not as institutionally foreboding as is, characteristically, the typical emergency room entrance.

The core staff of the clinic should include members of the medical and surgical house staff, residents and attendants on call, to render emergency medical and surgical care. This cadre should have special training in the principles and techniques of disaster and rescue medicine. Additionally, it should be staffed with personnel—psychiatrists, psychologists, and psychiatric social workers.

In addition to their regular professional competences, the staff should be particu-

larly well-trained in the organization and functions of community service and emergency agencies—medical and other. All members of the staff should be thoroughly trained in disaster and rescue medicine, safety, and first aid. They should have available, as standard and *ready* reference, all publications bearing on rescue, relief, and poison control operations. In short, they should be able to carry on all of the functions ordinarily performed by Poison Control Centers, Alcoholics Anonymous, Addicts Anonymous, Suicide Bureaus, Emergency Rooms, and Emergency Mental Hygiene Clinics.

The cost of this service would more than pay for itself not only in the lives saved and suffering relieved but actually in dollars and cents as well, for this is the kind of service which voluntary community agencies, governments, and the people-at-large will surely sponsor and support in their hospitals.

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ABRAHAM M. ZEICHNER, Ph.D.

Impact of admission to a mental hospital on the patient's family

The family is the basic unit of growth and experience, fulfillment or failure. It is also the basic unit of illness and health. . . . It is small wonder, therefore, that we accept its role in our lives so naturally, so unthinkingly.¹

The anonymity of patient life in the gigantic mental hospital stands in sharpest contrast to the intimacy of relationships within the family. Yet it is from life within a family that nearly all patients come to mental hospitals, and it is to their families that these patients will return—those of them who find within the hospital or within themselves a strength that sufficiently rebuilds and heals.

This paper reports some findings of a study of the impact on families of the hospitalization of a member for a mental illness and reports, specifically, findings concerning the ways families tried to cope with the illness up to the point of the patients' admission to a hospital.

The reported findings were developed from interviews with members of the families of 109 patients admitted to Con-

necticut's three state mental hospitals between December 1, 1958, and February 28, 1959. These were first-admission patients between the ages of eighteen and fifty-four, inclusive, but patients with a diagnosis of alcoholism or addiction were excluded.² These 109 patients constituted one-third of the first admission patients in this age range admitted to the three

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¹ Ackerman, Nathan W., *The Psychodynamics of Family Life* (New York: Basic Books, Inc., 1958), p. 15.

² Subsequent examination of hospital records revealed that 4 of these patients actually had readmission status and that three patients proved to be between fifty-five and fifty-seven years of age. It was not feasible to exclude either group from the analysis.

hospitals. The family members were interviewed in their own homes within three weeks of the patient's hospitalization.

RECOGNITION AND ACCEPTANCE OF MENTAL ILLNESS

The study revealed a considerably greater recognition and acceptance of mental illness on the part of the patients' families than the investigators had anticipated. Even so, nearly one-fifth of the families persisted in denying either the existence of an illness or its nature even after the patients' hospitalization.

Two-thirds of the families indicated that they had themselves recognized the illness as mental in nature, and an additional one-sixth had acknowledged it as such when confronted by a physician's opinion.

TABLE 1

Acceptance of diagnosis of mental illness by patients' families

ACCEPTANCE OF DIAGNOSIS	NUMBER	PER CENT
Recognized by family as mental illness	72	66.1
Acknowledged as mental illness when diagnosed	18	16.5
Denied as mental illness, regarded as physical	14	12.8
Denied as any illness	5	4.6

The patient himself was reported to have been the first to recognize his illness as mental in nature in at least 16 (14.7 per cent) instances, while other members of the immediate family were the first to note it in 49 cases (45 per cent). In 40.3 per cent of the cases, the initial recognition of the mental illness was by someone outside the family. Most often this was a physician (34 cases, 31.2 per cent); but

others—police, prison and jail officials, employers, a minister, a judge, a neighbor—accounted for 10 cases.

An examination of the length of time which elapsed between the initial recognition of the patient's mental illness and his hospitalization revealed a bimodal distribution. Of the 90 families who had accepted the diagnosis of mental illness, there were five who did so only following the patient's admission to the state hospital. Among the others, a large group had been aware of the illness for a long period of time, while another large group had recognized the mental illness only within the three-month period preceding hospitalization. Certain other findings pertaining to familial and occupational role performance indicate that this probably reflects the lapse of time between the onset of the illness and hospitalization rather than a pattern of delay in recognition of an illness as mental.

Family attitudes toward the patients' illness. It proved to be impossible to separate, in any clear-cut way, the families' attitudes toward the patients' illness from feelings about the whole complex of behaviors—the patients' and other peoples'—that were climaxed by the patients' hospitalization. Nonetheless, it was possible, in every case but one, to characterize the families' feelings toward the patients' illness. In that single instance, the interviewer did not penetrate the family's denial that the patient was or had been, in any way, ill.

Family attitudes ranged from the "sympathetic understanding" that was the good fortune of 50 patients to the overt hostility which the behavior of 7 patients evoked. The dominant affect in the response of the families of 12 patients had been fear, and it was noted that many other families related their fears of what the patients

TABLE 2

*Time elapsed between recognition of illness and hospitalization **

TIME ILLNESS ACKNOWLEDGED BY PATIENT AND/OR FAMILY	RECOGNIZED AS MENTAL ILLNESS		VIEWED AS PHYSICAL	
	Number	Per cent	Number	Per cent
After hospitalization	5	4.6	0	0.0
Just prior to hospitalization	24	22.0	4	3.7
Within 3 months of hospitalization	19	17.4	2	1.8
More than 3 months, less than 6	6	5.8	1	0.9
More than 6 months, less than 12	7	6.4	2	1.8
More than 1 year, less than 2	3	2.8	1	0.9
More than 2 years before hospitalized	26	23.9	4	3.7

* Excludes 5 patients whose families denied any illness.

might have done. The response of 15 families was characterized as "puzzled," for they seemingly had been unable to comprehend what had been happening. There were 24 families whose clearly mixed feelings were classified as "ambivalent." Commonly, these latter vented anger, but, along with it, expressed chagrin, puzzlement, fear, and guilt. Frequently they spoke with outrage of the patient's actions and then offered excuses, but of a sort and in a way that seemed to indicate little real understanding of the ill patient.

It was this understanding—acceptance—of the patient as a sick person, unable to control the behavior that engendered fear, apprehension, or disgust, that underlay the attitudes brought together in the classification "sympathetic understanding." Its relative absence was characteristic of all the others. This failure to understand and accept may be indicative of limited knowledge of mental illness, but the extent to which starkly negative feelings emerged suggests that the problem is far more complex for many patients and their

families. Still, ignorance—an almost primitive, superstitious view of mental illness—was seen sufficiently often to justify further study of the extent to which the problem faced by some families might be alleviated simply by additional and more accurate knowledge.

FAMILIES' WAYS OF COPING WITH PATIENTS' ILLNESS

Just as somewhat more than half of the families were unable to accept the patients' illness to an extent that would enable them to respond with sympathy and understanding to the disturbance, so those families' efforts to cope with the patients' illness tended to reflect their confusion and ambivalence. As would be expected, there were occasional responses that reflected grossly pathological relationships within families, but beyond these, a wide range of methods for dealing with the ill members was found. There were a considerable number of families (29.4 per cent) in which no change in family structure (other than the patient's absence) or functioning could

TABLE 3

*Families' ways of coping with patients' illness
and their attitudes toward the illness*

FAMILY ATTITUDES TOWARD PATIENTS' ILLNESS	METHODS OF DEALING WITH PATIENT					
	Total	No change ^a	Expected less	Made dependent ^b	Provoked	Appeased
Sympathetic understanding	50	16	22	9	1	2
Fear	12	2	7	3	0	0
Puzzled	15	8	3	3	0	1
Hostile	7	0	1	0	5	1
Ambivalent	24	5	11	4	2*	2
Persistent denial	1	1	0	0	0	0

* Includes all families whose methods of dealing with patient could not be classified otherwise.

^b Includes only patients relegated to a virtually completely dependent role in the family.

* In both these cases, there were important aspects of appeasement, but the provocative responses appeared to dominate.

be identified, but these included the families of which patients really had not been members and cases of such sudden onset that the families' adjustment was to the absence of the hospitalized member and not to his presence as an ill person; it included, also, some cases where the families' adjustments were of such long standing and had developed so gradually—long before the patients' illness had been recognized—that no change in family response following upon the recognition of the illness could be identified.

Families' ways of dealing with the patients and their illness were identified and classified for 77 families. By far the largest group of these had sought an adjustment by expecting less of the patients. Other family members took over responsibilities formerly assumed by the patients. Husband and children did the housework that the ill housewife left undone. Wife and children sought work or applied for public assistance, accepting lowered living standards when the incapacitated breadwinner ceased to work regularly.

Another considerable group of patients had been relegated to roles of almost complete dependence. A few had been enthroned in their invalid status by their families, but more commonly they appeared to have been pushed aside and largely ignored as the active life of the remaining family passed them by. About half of the families who took this course seemed to do so with a minimum of conflict; these included the families of two patients who were seriously mentally retarded and at least two more who had gross physical incapacities of long standing. For these patients and families the dependency had at least the appearance of a reality adjustment. However, this relegation to a dependent role had occurred as well within the context of less constructive attitudes toward patients.

Separations that made evident the family's rejection of the patient, threats and feuding were the responses of several families, including one in which the family's attitude toward the patient was classified as "sympathetic understanding."

Here, the alcoholic husband, sober when interviewed, conveyed an impression of considerable insight into the dynamics of the relationship of his drinking and drunken quarrelsomeness and his wife's illness. Except for that one instance, the family responses that were openly and intentionally provoking were concentrated in those families that expressed feelings of active hostility toward the patients.

Action by families to deal with the illness. All but 11 of the families interviewed reported seeking outside help in dealing with the problems associated with the patients' illness. These 98 families reported turning to 201 sources for help. Physicians and psychiatrists constituted by far the largest resource groups, totaling together the objects of 122 ventures for help on the part of families. Hospitals and clinics were additional medical sources to which these families turned. Sixteen

families sought help from the clergy, and a few turned to social agencies.

That only a few asked help of the social agencies and community psychiatric clinics that have been established for this purpose may reflect a lack of knowledge of their availability, but the Hollingshead and Redlich findings suggest a possible relationship to families' social class position.⁸ Unfortunately, this phase of the study did not develop data by which the social class position of the families could be ascertained.

Such findings point a direction for further study, as does the finding that 58 of the 98 families who sought help went to more than one source in this search. On the average, they went to three different sources for the help they needed—a num-

⁸ Hollingshead, August B. and Frederick C. Redlich, *Social Class and Mental Illness* (New York: John Wiley & Sons, 1958), p. 187.

TABLE 4

Families' assessment of the helpfulness of resources utilized by them

SOURCES OF HELP UTILIZED	APPRAISAL OF HELPFULNESS				
	Total	Helpful	Partly helpful	Not helpful	No opinion ^a
Physician	72	33	15	19	5
Psychiatrist	50	14	12	18	6
Hospital ^b	27	14	4	7	2
Clinic	11	3	1	6	1
Clergy	16	4	4	5	3
Social Agency	5	2	1	2	0
Police	9	5	1	0	3
Other ^c	11	5	1	4	1
None	9	0	0	0	0
Unknown	2	0	0	0	0

^a Families unable to give an appraisal of helpfulness or reluctant to do so.

^b Includes general hospitals, VA hospitals, private sanatoria.

^c Includes attorney, chiropractor, nurse, friend, neighbor, parole officer, etc.

ber of them without ever feeling that they received it.

Families' assessment of the helpfulness of resources tried. The family members interviewed were asked to share an appraisal of the helpfulness of the response received when they sought help outside the family. Of the 201 ventures for help which families made, they considered 80 to have yielded definite help and an additional 39 as partly helpful. On the other hand, 61 sources had proved not helpful.

TREATMENT PRIOR TO HOSPITALIZATION

One aspect of the study was a careful exploration of the participation of physicians, especially family physicians, in the process of admitting patients to the state mental hospitals and of their roles with patients and families during the period preceding hospitalization. In addition to the information secured from families, questionnaires were sent to physicians who were identified as having either counseled with the family or treated the patient.

About four of every five families in the United States are said to have family physicians to whom they turn regularly when a member is sick.⁴ This ratio was duplicated almost exactly among the families interviewed for this study, for 84 of the 109 families identified family physicians; 21 reported that they had none; and the information was not available for 4.

Patients treated by family physicians. Although 84 families claimed family physicians and 72 reported that they had consulted these or other general practitioners about the problem the patient's illness

made for them, only 55 of the patients were reported to have been treated by these physicians prior to hospitalization. Even so, family physicians constituted the most used treatment resource.

Psychiatrists in private practice had seen 44 patients, and 11 had received some care at community mental hygiene clinics. It was found that 25 patients had been hospitalized in private psychiatric hospitals or on the psychiatric wards of general (including VA) hospitals.

An unduplicated count shows that at least 63 of the 109 patients (57.8 per cent) had been attended by a psychiatrist prior to hospitalization. The families of at least a few additional patients had consulted with psychiatrists in the community although the patients themselves had not been seen.

Families' perception of the helpfulness of treatment. It was not within the scope of this study to examine the nature and results of psychiatric or other treatment received by patients prior to their hospitalization, but the family members who were interviewed were asked to comment on the helpfulness of such treatment as the patients had received. Since it was not possible to establish the nature of the treatment beyond the families' knowledge,⁵ these responses were highly impressionistic and, as did answers to related questions, tended to highlight rather than to clarify ambiguities.

Of the 55 patients treated by family physicians, the families of 15 characterized the results, without qualification, as helpful, while 11 families were equally definite in saying that the treatment had not helped. The families of only 5 of the 44 patients seen by private psychiatrists described the experience as helpful, while 13 expressed a definite negative opinion. It was the view of the families of all 11 pa-

⁴ "A View of Our Family Physicians," *Progress in Health Services*, 7 (June, 1958), 6.

⁵ Data from the questionnaires received from family physicians are not reported in this paper.

tients receiving clinic treatment that none had been helped.

Duration of treatment prior to hospitalization. Family members were able to provide information about the length of time patients had received treatment prior to hospitalization for 40 of the 55 patients treated by family physicians and for 38 of the 44 who had been treated by psychiatrists in private practice. Of the former, 7 first went to the physician less than a month before their admission to the state hospital, but nearly half (18) had been treated for the illness by their family physicians for longer than a year. In contrast, of the 38 psychiatrists' patients, 14 were first seen within a week of admission, and only 5 had been treated for as long as six months. Information concerning the length of treatment was available for 8 of the 11 clinic patients. Of these, 6 had been seen at the clinic for less than a month and the other 2, for less than six months.

SUMMARY

This paper has reported findings concerning the ways families try to cope with the problems presented by the mental illness of a member and the families' appraisal of the effectiveness of those efforts. Two-thirds of the families of 109 patients admitted to state mental hospitals had recognized the nature of the patient's illness as mental, but more than one-sixth persisted in viewing the illness as physical or in denying that the patient was ill in any way.

Family attitudes toward the ill patient were classified, and the families' ways of adapting to the patients' illness were examined. Attitudes ranged from "sympa-

thetic understanding" to overtly expressed hostility, with groups of substantially equal size viewing the patient with sympathetic understanding and being fearful, puzzled, or ambivalent. The mode of adaptation characteristic of all attitudes except the overtly hostile was to expect less of the patient and attempt role substitution by other family members. However, a considerable number of families relegated patients to a virtually completely dependent position, and some resorted to appeasement.

Nearly all families turned for help to resources in the community, and four-fifths of these resources were medical. Family physicians were most frequently turned to, by a considerable margin, but substantial numbers of families consulted with psychiatrists in private practice or at community hospitals or clinics. About 70 per cent of the resources to which families turned were perceived as having been helpful in some degree.

Families consulted medical resources for help with the problem presented by the patients' illness more frequently than patients received medical care for the illness prior to hospitalization, but nearly 60 per cent of the patients had received some psychiatric attention before they were hospitalized.

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Survey of employment experiences of patients discharged from three state mental hospitals during period 1951-1953

This is a condensed report of the second phase of an extended study which began with a survey of "Employers' Attitudes and Practices in the Hiring of Ex-Mental Patients."¹ The current study presents

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¹ See *Mental Hygiene*, 42(July 1958), 391-401. Both studies were cosponsored by the Office of Vocational Rehabilitation and the Massachusetts Association for Mental Health. This latter study was completed in one year, between June, 1957, and June, 1958.

some findings, interpretations, and conclusions based on employment experiences of individual patients discharged from mental hospitals. The focus of this study, although serving to highlight the vocational aspects of the rehabilitation process for ex-mental patients, necessarily sets limiting conditions for an adequate elucidation of other relevant variables of personality, not specifically vocational, which are involved in the total rehabilitation process.

METHODOLOGY

Specifically, the authors attempted to investigate the vocational adjustment of a sample of patients released during the period 1951-1953. This period of time was selected in order to provide a reasonably long term follow-up which would throw light on the problems and processes

associated with the ex-patients' varied experiences in the labor market. The survey was conducted in the Greater Boston area, the same geographical area which formed the context of the employer study referred to above.

A sample of 370 patients was secured from a population of almost 3,000 patients² released from three typical state hospitals during a three-year period. From the sample population, 160 patients interviews were completed; 120 patients could not be located, and 90 patients, although located, could not be interviewed for a variety of reasons. Information was secured for 54 patients from relatives of this group of 90 patients.

The major factors characterizing the sample population were: a history of hospitalization of at least 90 days duration, with a median stay of one year; ages falling between 22 and 45; free from secondary disabilities associated with minority group status, physical illness, or deficient mentality. The focus of the study was the factor of a history of mental hospitalization in relationship to employer receptivity and vocational adjustment. Such a sample was calculated to test some of the currently held assumptions regarding the effect of mental hospitalization on employment opportunities and success. Hence, this sample is not necessarily representative of either the resident hospital population or the total population of released patients.

Generally all information, except for diagnosis, length and frequencies of hospitalizations, which were taken from hospital records, was secured from a single face to face interview with each patient. In some cases, supplemental information was secured from family members. The interview was informal and unstructured and was conducted in the ex-patient's home. The interviewer was a psychiatric

social worker with considerable clinical experience in mental hospitals.

MAJOR FINDINGS

The most significant fact arising out of the present study is that all patients within the interviewed sample (160), able and willing to work, were employed. Few patients were unemployed because of the *alleged* and real resistances of employers. A history of hospitalization for mental illness was not a necessary deterrent to employment. For the most part unemployed patients were unemployed because they were *unable* and *unwilling* to work.

Of the 160 patients interviewed, 115 were found to be employed between three and seven years after their hospital release. The remaining 45 were found to be unemployed, with the bulk of them not just currently unemployed but idle during much of the time subsequent to their release, and more than half employed only intermittently, if at all, premorbidly.

COMPARISON OF EMPLOYED AND UNEMPLOYED POPULATION

The employed population can be divided into three sub-populations: the *re-employed*, and *stably* employed, and the *marginally* employed. Each of these sub-populations will be discussed and compared.

The Re-employed

Almost one out of five of the employed ex-patients returned to former employers after their hospital release.

Examination of the data reveals that by

² Patients were eliminated who had less than 90 days of hospitalization, who were under 22 and over 45, and who had a major secondary disability or who belonged to a minority group. Housewives not planning to seek employment were also rejected.

all measures this group is the healthiest of all the employed ex-patients interviewed.

First, they spent less time in the hospital than the stably and marginally employed, with the majority spending less than a year in the hospital.

Second, they were less frequently found with a diagnosis of schizophrenia and were most frequently diagnosed as manic-depressive. A few were diagnosed as non-psychotic.

Third, almost half were married and living with a spouse.

Fourth, occupationally, they continued the longest with a single employer, post-morbidly as well as pre-morbidly, the large majority working in at least one job three years continuously sometime prior to hospitalization and for at least two years subsequent to hospitalization.

Fifth, socially⁸ they tended to participate normally in the activities characteristic of their class group. There was only occasional evidence of marked withdrawal and isolation.

The Stably Employed

Close to the re-employed, but different from them, were a group of about 80 ex-patients in the employed population of 115, whom we describe as stably employed.

First, they spent more time as patients than the re-employed, with a majority spending more than a year in the hospital.

Second, they were more frequently diagnosed as schizophrenic with almost three-quarters of them so classified, compared to two-fifths of the re-employed so designated.

Third, only one-fifth of the stably employed were married compared to almost half of the re-employed.

Fourth, occupationally, the stably employed are not too dissimilar from the re-employed, differing basically in their tendency to change jobs more frequently. About 33 per cent of the stably employed, compared to almost 80 per cent of the re-employed, had only one job post-morbidly. Pre-morbidly, less than half of the stably employed group compared to 85 per cent of the re-employed worked at least three consecutive years with the same employer.

Fifth, socially they tended to be less outgoing than the re-employed, with marked tendencies toward withdrawal from group activities but with a large minority participating normally in social activities characteristic of their group.

The Marginally Employed

A small group of about 15 ex-patients were designated as marginally employed. In many ways, they are closer to the unemployed than the stably employed. Much of the data supporting our judgment of this group is of a qualitative nature, since, statistically, we had combined them with the stably employed because we did not become aware of them as a distinct group until after our statistical tables were completed.

First, they tended to spend more time in the hospital than the stably employed.

Second, they were almost invariably found in the schizophrenic group.

Third, almost all of them were single.

Fourth, occupationally, they were doing poorly, changing jobs frequently and erratically, and showing little insight into their difficulties. Their ability to secure jobs and their inability to hold them were impressive. One illustrative case is that of

⁸ We recognize difficulties of making judgments of mental health from the degree of social participation or withdrawal alone. Factors of ethnicity and class further complicate such efforts at evaluation.

Employment experiences of patients

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a young female clerical worker who, within a single year, secured as many as 11 jobs.

Premorbidly, many of them were frequent job changers. We did not include eight patients in this group despite the fact that they had changed jobs frequently, i.e., four or more times following their release from the hospital. The evidence in these eight cases was such as to suggest defensible reasons for change, ascribable either to personal factors or to factors associated with the particular industry. As an example, it is not unusual for a construction worker to change jobs frequently. Moreover, these eight patients in the interview situation were, by and large, able to account in a logical way for their job changes. Some secured improvements in wages or in working conditions as a result of their changes. By way of contrast, the marginally employed reported no gains to justify their job changing.

What is perhaps remarkable about the marginally employed is their continuing interest in work and the great effort they expended in finding work. In addition, they manifested great endurance of repeated rejections following their initial acceptance on a job.

Fifth, socially this group were generally living lives of isolation and loneliness, lives of quiet desperation.

THE UNEMPLOYED

The unemployed, numbering 45, seem to be a distinct population, qualitatively different from most of the employed population. The question arises: would these unemployed patients be currently unemployed if appropriate help had been available at the time of their release? Although our data do not permit a positive answer, we would tend to have a pessimistic view for two reasons: (1) Many of these un-

employed patients had been chronically unemployed throughout their lives. (2) Many of them had been released without any noticeable improvement in their condition.

First, they spent more time in the hospital than members of the employed population. Only five (11 per cent) of the unemployed had spent less than six months in the hospital compared to thirty-one (27 per cent) of the employed.

Second, diagnostically, they are most frequently found among the schizophrenics; 95 per cent of the unemployed compared to 70 per cent of the employed were so classified.

Third, by marital status they do poorly, with 91 per cent single compared to 60 per cent of the whole employed population.

Fourth, occupationally they have done worse premorbidly than the employed. More than half of them had worked irregularly or not at all compared to one-third of the employed group, who had been marginally attached to the labor market. Only 26 per cent of the unemployed were stably employed as measured by attachment to one or two employers compared to 50 per cent of the employed. As a further measure of job stability, only 33 per cent of the unemployed worked for a single employer for three years or longer compared to 55 per cent of the employed population.

Fifth, socially, almost without exception, they are confined to their homes and enjoy very few social contacts and participate hardly at all in any activities.

Lastly, almost half of the unemployed were found in the younger range of the sibling order (4, 5, 6, etc.) compared to less than a fourth of the employed who were so located in the sibling sequence, suggesting the possibility that many of the

unemployed have more intense dependency needs than the employed.⁴

Looking at the unemployed population qualitatively, we can divide it into two sub-populations; the employable unemployed and the unemployable unemployed. Of the 45 unemployed ex-patients, we estimated that about one-fourth of them might be moved into employment with appropriate help. A few of the group were unemployed for personal reasons; one was home recuperating from an auto accident; another was home caring for an ailing mother. This small group of employable unemployed were so designated on the basis of their current recovery, their premorbid work history, and their seeming willingness to accept help if available. The other and larger group of unemployable unemployed were so designated on the basis of the following factors: persistence of symptoms; no insight into illness; unwillingness to accept help; little or no work history prior to their hospitalization; complete withdrawal at home. In a sense, this group appears to have made illness their career. And, at present, given our current psychiatric limitations in terms of treatment and resources, to say nothing of ex-patients' resistances to help, it would appear to be most difficult, if not impossible, to move this latter group into employment: that is, regular employment within the competitive labor market.

EMPLOYMENT EXPERIENCES AS GLEANED FROM COLLATERAL POPULATION

As previously stated, 90 of the 250 located patients were not interviewed.

⁴ This relationship was brought to our attention by Dr. Herbert Lipton who tabulated the data of this study.

However, 54 nonpatient interviews were secured from a parent or relative. This offered us an additional source of data for exploring the capacity of ex-patients to find work.

Of the 54 patients, 13 were not available for employment: 63 per cent were employed; 24 per cent were unemployed; 13 per cent could not be described jobwise because of lack of information. About one-eighth of the employed group were marginally employed and were working irregularly. This occupational distribution compares favorably with that of the directly interviewed ex-patient sample.

In addition to these occupational similarities, the collateral group resembled the interviewed sample by age, sex, number of hospitalizations, age on onset, and education. Maritally, the collateral population resembled the employed part of the sample.

EMPLOYMENT EXPERIENCES OF LOST POPULATION

It will be recalled that 120 patients of the sample of 370 could not be located. Some information on this lost group was obtained, therefore, from hospital records. On the basis of such data, the following trends were found:

1) One out of six had a history of alcoholism in addition to their major diagnosis. Among the interviewed sample, there were only a few alcoholics.

2) Fifteen per cent were divorced or separated compared to six per cent of the employed group, five per cent of the re-employed group, and seven per cent of the unemployed group.

3) Thirteen per cent had better than high school education compared to 32 per cent of the employed group, 40 per cent of the re-employed group, and 24 per cent of the unemployed group.

4) Fifty-two per cent were over 40 years

old compared to 35 per cent of the employed group, and 31 per cent of the unemployed group.

Specific occupational information was lacking. However, the above findings indicate that this lost population is composed of less adequate individuals who would be likely to fall into the unemployed or marginally employed population. This suggests that their assumed unemployment might not be ascribable to their history of hospitalization for mental illness, but rather to their persistent symptomatology, which renders them less able to work and to attach themselves stably to others in the community.

JOB MOBILITY: PRE-HOSPITAL AND POST-HOSPITAL

The question arises: How does a history of mental hospitalization affect job mobility?

The majority of employed ex-patients (77 per cent) stayed at the same occupational level of skill. Eleven per cent moved downward and five per cent moved upward. For seven per cent, no determination could be made regarding direction of job change. Interestingly, all 20 re-employed patients continued at the same level of skill. Again, we find support for the fact that mobility, as for the normal labor force, is essentially intergenerational.⁵

UNDEREMPLOYMENT

By underemployment, we mean employment at a level of skill below that for which one is qualified by training and experience. A clear example would be that of a college graduate working as an elevator operator or a skilled machinist working as a janitor.

Are ex-patients generally underemployed? Thirty-three per cent of the total

employed group have gone beyond high school, having completed between 13 and 16 years of schooling, whereas 40 per cent were doing professional, semi-professional, clerical, or skilled work. Thus, it would appear that although there may exist individual cases of gross underemployment, generally the ex-patient population seems to do no worse than the general labor force.⁶

WORK CAPACITY

Our data would support the growing evidence that ex-patients have less difficulty adjusting to work roles than to social and family roles. The capacity of some very sick patients to work is impressive. Our data would suggest, too, that work, for many ex-patients, is their major and only tie to the community. It would appear to be their major bulwark against regression.

What we are unable to explain with our data is why some sick patients can and do work while others accept and need idleness. Role responsibility within the family seems only a partial explanation, since two-thirds of the employed group and two-fifths of the re-employed were single, many of them living in the parental home, and only a few of them having the major responsibility of supporting their families.

The ability of some very sick patients to work serves to reinforce their tendency to deny their illness. Since they are engaging in a normal adult activity, they tend to see themselves, and are seen by others, as being well.

⁵ Bell, Daniel, *Work and Its Discontents* (Boston: Beacon Press, 1956).

⁶ Ginzberg, Eli, *Human Resources* (New York: Simon & Schuster, Inc., 1958).

PREMORBID WORK HISTORY AS A PROGNOSTIC FACTOR

The capacity of ex-patients to do the unexpected makes vocational prognosis difficult, if not impossible.

However, our data would point up the fact that by and large those ex-patients who have done well vocationally pre-morbidly are the very ones who are likely to do well postmorbidly. And although some ex-patients who had done well pre-morbidly fail to recover their vocational capacity, the converse rarely seems true: i.e., few ex-patients seem able to reverse a poor pre-morbid work history. It is possible to argue that this group is judged a poor risk during their periods of hospitalization and are not offered very much help compared to the help offered the ex-patients with better work histories. However, our data would suggest that the absence of help was not the major factor accounting for continuance of a poor pre-morbid work history, since many of the other ex-patients who were working received little or no help while in the hospital.

JOB CHANGING AND A HISTORY OF HOSPITALIZATION FOR MENTAL ILLNESS

There is little doubt that some ex-patients were restrained from changing jobs or employers because of anxiety associated with their history of mental illness, but there was no evidence that these anxieties constituted a major source of deterrence to changing either jobs or employers among the majority of ex-patients interviewed.

In fact our evidence would suggest the contrary: that some ex-patients changed

jobs too frequently, and the causes of these changes were not always for defensible reasons. In large measure, the best adjusted ex-patients tended to change jobs or employers less frequently than the poorly adjusted ex-patients within our interviewed sample.

A proper assessment of norms of job changing,⁷ it is recognized, would entail a consideration of some of the following factors: age, sex, skill level, health status, race, ethnicity, personality, and labor market conditions.

But pending a more complete assessment than one effected with our interviewed patients, our data would suggest that changing jobs frequently rather than attachment to a single job or employer would indicate emotional instability. Our data would also suggest that few ex-patients were inhibited about changing jobs because of their history of hospitalization for mental illness.

JOB SATISFACTION

Our data would suggest that our interviewed population of employed ex-patients were no more satisfied or dissatisfied with their jobs than the normal work force, and that, like the normal work force, job satisfaction varied directly with the level of skill: i.e., the more skilled the work, the more the resulting satisfaction.

However, there was some evidence that some ex-patients working on unskilled levels of work were not too dissatisfied since it provided them with what they desired most: occupation of their time and a fixed daily routine, besides the financial means for support.

What perhaps is interesting to note is that the unemployed, with few exceptions, unlike the normal unemployed, showed little or no dissatisfaction with their status.

⁷ Soule, George, *Men, Wages, and Employment* (New York: Mentor Press, 1954).

EMPLOYMENT AND A HEALTHY LABOR MARKET

Would the employed ex-patients have been able to find employment so readily if they had entered the labor market during less favorable times than obtained for our sample population?

The answer is obviously no. Under adverse economic conditions producing higher job specifications and increased competition for jobs, it is probable that the identified ex-patient would experience greater difficulty than the normal individual or the unidentified ex-patient.

In analogous fashion, older ex-patients and ex-patients of minority groups, or ex-patients with secondary disabilities (those excluded in our sample) would have probably experienced greater difficulty finding work than our interviewed sample. However, this added difficulty would not be the result of their history of hospitalization for mental illness alone but the result of employer prejudice against such fairly visible factors as age, minority group status, and physical disabilities.

EX-PATIENTS' ATTITUDE TOWARD THEIR MENTAL ILLNESS^a

How do ex-patients conceptualize their mental illness, its causes, and "cure"?

Few ex-patients within the interviewed population seemed to have very much understanding of their illness. Some felt protected by this lack of understanding. One patient, in fact, said that he did not ask the hospital doctor what was wrong with him, feeling that it was none of his (the patient's) business.

As to causes, only very few patients approached what would be a sophisticated explanation. Many attributed their illness to overwork, overfatigue, excessive

drinking, heated arguments, physical illness, worry, or to the malice of a spouse, sibling, or parent. Some equated it with and concealed it behind physical illness. A few, however, recognized a sharp difference between mental and physical illness and wished that they had been stricken with heart disease or cancer. At least then, they thought, they could put their finger on it. The lack of concreteness and definiteness of mental illness lent to it an elusiveness that was disturbing to them.

Given this lack of understanding, for whatever reason, it is not illogical to find that many ex-patients have developed the point of view that their staying well depends on suppressing the unpleasant experience of illness and of "closing the book" on it. They see no function in reopening the past and stirring up memories. It seems best "to forget it as if it had never happened." There is "nothing to be gained" by discussing it. The conviction seems implicit that the *threat* (apparently ever present) of relapse can be ward off by keeping memories of illness shut out. (This view of staying well by "closing the book" is widely supported by relatives of ex-patients.)

A social value that many patients have adopted is that staying well depends on the patient's own strength to help himself. This ideology works both ways and probably helps keep some patients well as it serves to maintain the pattern of illness of others.

This tendency and desire to "close the book" seems related, too, to feelings of

^a In reading this, some account should be taken of the tendency for retrospective distortion by the respondent as well as the fact that the majority of respondents were from the working class.

shame. Patients may not understand mental illness, but they do understand the low valuation of mental illness prevalent in our society. And even those patients who say that "mental illness is like any other illness" and "there is nothing to be ashamed of" are still reluctant to talk about it as they would any other illness. These patients seem to state too vigorously and repetitiously this feeling that there is "nothing to be ashamed about." The intent seems aimed at convincing themselves rather than others. Many patients, on the other hand, admit that mental illness is something to be ashamed of and get support of this view from their relatives.

Related to this disinclination to talk about their illness is the patients' attitude toward aftercare clinics. Although some ex-patients spoke favorably of them, many expressed negative feelings toward them because they serve to remind them of their illness, and many patients deliberately hold back information during these clinic visits because of their fear of rehospitalization. Thus, even within a medical setting, they feel too anxious to talk freely about their illness.

To achieve this objective of shutting out the past, many patients have worked out an ideology of activity. Keeping busy (and avoiding idleness) is one way of keeping the mind uncontaminated by the past. Another way of keeping healthy is to get plenty of sleep. Thus, between busyness and sleep, the mind is not kept occupied by thoughts of past illness. (Of course, long hours of sleep solve for many ex-patients their inability to use their leisure time constructively.

From a layman's point of view (i.e., the ex-patient's) it can be argued that they indeed have little to gain by talking about their illness and perhaps it is *functional* for them to "close the book on it." Again,

ex-patients can never be sure of the responses they will produce in others in talking about their illness. Until, therefore, there is greater understanding of mental illness generally and until society accepts mental illness as it does other illnesses, these patients may be most discreet in keeping their past "shut out." In practical terms, too, for many ex-patients mental illness means the crowded and impersonal state mental hospital and frightening shock therapy, both provoking enough nightmarish qualities to discourage thinking and talking about their episodes of illness.

INFORMING THE EMPLOYER— WHOSE DILEMMA?

It is part of the labor market tradition for a seller (a job applicant) to talk about his assets. And the prevailing doctrine of *caveat emptor* gives sanction to this practice as well as warning to the buyer (the employer). The majority of ex-patients know that a history of mental illness is not a job asset, and it is best, therefore, not to talk about it. Part of the reality of getting a job is putting one's best foot forward. The majority of ex-patients who succeed in getting work do not talk about their illness. One fourth of the ex-patients, however, began by so informing the prospective employer, and soon learned that if they were to find employment, then discretion is the better part of candor. After experiencing several rejections, they learned to emphasize their assets. Also, in time, as they moved away from the hospital, some ex-patients felt less the need to make reference to it. Thus, for some ex-patients, there was a smaller likelihood of telling a second employer than a first, following hospitalization.

The fact that emerges is that about three-fourths of the ex-patients do not

identify themselves as such in the labor market. This helps to explain the finding reported in the previous study that few employers had experiences with the employment of ex-patients.

What is also interesting is that about one-fifth of the employed patients secured work despite the disclosure of their illness. Apparently telling about one's hospitalization is not necessarily fatal if one looks and acts well enough to be considered recovered. This is borne out in part by the experiences of the unemployed group who did not get hired even though they said nothing about their illness. It seems most expedient usually not to tell, but probably if one talks about one's illness appropriately and if one acts appropriately to support the talk, it is possible for the identified ex-patient to secure employment.

The implicit assumption persists that most ex-patients feel intermittently uncomfortable about having to conceal their hospitalization experience. There is little evidence in our data to support this assumption. Most employed ex-patients accept such concealment as an act of prudence and one of the ways of coming to terms with the reality of the job world.

It would appear, rather, that many ex-patients feel uncomfortable talking about their illness, especially to those who they feel are not likely to be understanding. And many ex-patients feel that their illness is in the *past*, and there seems to be little point in talking about it. This attitude is not infrequently given support by members of the family who share the ex-patient's tendency to bury the illness in the past. Further rationale for not telling is that it is a private affair not relevant to a business transaction and that there is no point in talking about an historical fact of one's past illness since one

is currently well. "Wellness" is symbolized by release from the hospital.

But what is perhaps more interesting is that for many ex-patients the issue does not even arise. Being realists, they seek out the smaller employer⁹ who hires informally, and they avoid the larger employer who is likely to require the completion of a printed application form in addition to a physical examination. The ex-patients know that when a question on mental illness appears, an affirmative answer is likely to become a reason for rejection. The small employer does not usually make it his policy to ask applicants if they were hospitalized for mental illness. Again, since 60 per cent of the ex-patients work on semi-skilled, unskilled, or service jobs, they are in jobs which are not likely to provoke much scrutiny of their past, especially during periods of high employment.

In short, the evidence would suggest that most ex-patients are realistic at least within the job world and accept the prevailing practice of talking only about those factors which are job relevant and likely to serve to persuade the employer of their work capacity. There is some evidence that employers would be deterred from hiring patients who deviated from this practice. Finally, the issue of telling or not telling is often misperceived by some professional workers who regard it in moral terms and talk about the patient's "lying." Or, they assume that, invariably and uniformly, concealment creates great anxiety and that patients are completely immobilized by the fear of their discovery. No evidence was found in support of this assumption

⁹ This practice of seeking employment with the small employer does limit the employment opportunities of ex-patients, especially in an economy characterized by large scale industry.

except for a few patients. We suspect that ex-patients who are ambivalent about the prospect of working tend to displace this ambivalence to the problem of whether they should tell or not tell an employer. Some professional workers may react to the manifest aspects of this problem. In our view, the issue is not in those terms as presented by the patient, but rather in terms corresponding to the ex-patient's underlying need: does he want to work; can he work?

HOW EX-PATIENTS FIND JOBS

The majority of ex-patients find their jobs informally, through their own efforts or those of friends and relatives. This is in accord with the habits of the normal labor force of whom only a minority ever secure jobs formally through the intervention of an employment agency or a professional helper.

The fact that the majority of ex-patients enter the labor market in a way which accords with labor market traditions and employer expectations also serves to explain, in part, their ability to find employer acceptance.

TIMING RE-ENTRY INTO THE LABOR MARKET

There emerged among ex-patients a pattern which, although it is hard to describe, is identifiable. Each ex-patient seems to develop a feeling regarding his own readiness for work (as well as his own unreadiness.) Based on this feeling, some released patients enter the labor market almost simultaneously with their release; others will wait for several months, and some will hold back for as long as a year or more. This appears to be a highly variable matter. There is some evidence that a minority of

ex-patients have to be aggressively pushed into employment if they are to find work. Determination of the amount of guidance and support, if any, to be given to released patients should be based on careful clinical judgment rather than on assumptions of ex-patients' helplessness. Our data indicate that the feelings of released patients as to their work readiness would be one important criterion in arriving at such judgments.

The hospital practice of not infrequently conditioning release on the patient's finding work might tend to be self-defeating and discouraging to some ex-patients who have to bide their own time prior to seeking employment. Being ready for release and for work is not one and the same thing.

DETERMINING APPROPRIATE JOB LEVEL FOLLOWING RELEASE

Since three-fifths of the employed ex-patients were working in semi-skilled, unskilled, or service jobs, little judgment was required of them to determine an appropriate job level. They were already at the bottom of the occupational ladder.

For the remaining ex-patients, the majority returned to their premorbid job level.

A minority of ex-patients who had doubts about their work capacity returned to the labor market below their premorbid occupational level and experientially, both tested out their capacity for higher level work and developed strength for moving upward.

Eleven per cent of the employed ex-patients continued at an occupational level below their premorbid one. Whether this occupational decline was always justified was not answerable with the data available.

But some of the ex-patients may have found working conditions congenial to their needs, which they prized more highly than the appropriateness of work level.

There was some evidence expressed by a few ex-patients that their major consideration was staying well and staying out of the hospital. And for this group, work was looked on instrumentally, in the sense of serving their health needs. They were more concerned with staying well than with so-called job successes. This minority of ex-patients wished to avoid stress, and, thus, were satisfied with jobs requiring minimal responsibility. In a sense, some of these ex-patients regarded themselves as fragile and sought work that was not threatening to this fragility. In some cases, the families enhanced this feeling of fragility of some of the ex-patients.

SUMMARY AND CONCLUSION

Our findings raise questions concerning five commonly held assumptions:

1) That obtaining employment is *generally* a major problem for ex-patients;

2) That many ex-patients are unemployed because of negative employer attitudes;

3) That employed ex-patients generally fall into occupational levels below their capacities because of discriminatory practices;

4) That ex-patients feel intermittently uncomfortable about having to conceal their history of hospitalization from employers; and

5) That ex-patients *as a group* need and/or want active professional intervention in negotiating their return to the labor market.

FLORENCE BUSH PRESTON, M.A.

Combined individual, joint and group therapy in the treatment of alcoholism

Perhaps the original title of this paper, which was shortened for practical purposes, may clarify more definitively the subject for discussion: namely, "The Effectiveness of a Selective Combination of Individual, Joint and Group Therapy in the Treatment of Personal and Intra-family Relationship Problems in an Alcoholic Clinic." In this context, joint therapy, in contrast to group therapy, represents therapy with two members of a family as compared to several individuals, not necessarily members of the same family, as characteristic of the group therapy situation. The joint therapy in this discussion involves marital partners.

The idea of selectively combined individual, joint and group therapy, tailored, so to speak, to meet the psychological and social needs of the individual patient may, indeed, be new to many of you.

The individuals under discussion include men and women patients who were problem drinkers themselves or were spouses of problem drinkers.

Some mention of the philosophical framework should be made here with regard to symptomatology and dynamics generally. The symptom of alcoholism itself, it is fairly generally agreed, appears to be determined by environmental and cultural factors. The individual who has reacted to a long-time stress situation with excessive drinking may previously have made an adequate or satisfactory adjustment to life; however, he may, over a period of time, regress to a level, in terms of

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psychological and social functioning, similar to that of the so-called chronic problem drinker or compulsive drinker who reveals more severe pathology originating in an early period of his life and evidenced by difficulties in family, school, work situation, etc., from an early age. This has led many clinicians who have worked with alcoholics therapeutically, to the conclusion that the absence of a significant emotional relationship early in life or its counterpart, the presence of warped, inconsistent, or pathological relationships, contributed to the psychological and behavioral picture presented by the alcoholic.

This premise is substantiated by the problem drinker himself once he is engaged in therapy; the therapeutic relationship appears to meet, in some degree, the insatiable need as expressed by the symptom, and this can result in continued abstinence or a considerable modification of the drinking pattern upon his entrance into therapy and as he becomes better integrated and more mature. One young father of twenty-eight, with three children, who sought help when his wife was about to leave him because of his excessive drinking (begun in adolescence) was able, throughout a year of therapy and subsequently, to maintain abstinence and relieve excessive tension as he resolved many personal and family relationship problems. In this family, the nonalcoholic wife's personality problems were such that the prognosis for the future marital relationship appeared questionable, not from the standpoint of the husband's drinking problem, which no longer existed currently, but from the standpoint of the wife's emotional difficulties which began to be expressed in excessive social drinking and for which she could not bring herself to seek help. This is also an example of how one marital partner may become sicker in an ailing

and yet sustained marital relationship as the spouse improves through individual therapy.

Just as some problem drinkers have a basic, long-time personality difficulty which the compulsive drinking symptom expresses, and other problem drinkers seem to have regressed into excessive drinking in periods of crisis or tension, so the nonalcoholic relative represents a similar gamut of personality difficulties. The personal and interpersonal relationship problems presented by family members of the alcoholic may or may not be related to the alcoholic's drinking symptom. Some family members may be as sick or sicker emotionally than the alcoholic, but the drinking symptom itself and accompanying uninhibited behavior are so prominent that social non-acceptance (and prejudice) immediately give it primary importance to the community at large as the focus of all the family ills.

Some mention should also be made of the community facilities in relation to problem drinkers and their family members. Although there is not an alcoholic clinic in every community, there is an increasing number of social and health agencies where help can be found for the problem drinker and family members who seek it. In most communities there is an Alcoholic Anonymous organization whose members provide valuable help to the alcoholic and generally co-operate with existing agencies in facilitating treatment. The nonalcoholic wife may get help from A.A. through its Alanon group, and often this meets her needs, just as A.A. may meet the needs of her husband. The inspiration-repressive mechanism involved in this approach is effective and very helpful to many many people. Here they find a philosophy of life and people with whom to identify and discuss mutual problems.

Sometimes this leads to an interest in professional help, which they may seek for several reasons: (1) The husband's sobriety may not solve their marital problems as they had hoped it would; for instance, many wives discover difficulties in the relationship after sobriety that they had not been aware of before; (2) The sobriety itself might end; (3) Frequently, even after a successful period in A.A., one or both partners may feel uneasy, perhaps because of current stress in the life situation and fear that the heretofore smooth adjustment or sobriety is being threatened, and they feel the need of psychological help to avoid recurrence of the previous pattern. This help would be available through private psychotherapists and community agencies such as psychiatric clinics, family casework agencies, child guidance clinics, etc.

In discussing combined therapies, I plan to present, briefly, the main principles involved and the observed developments as they occurred.

To begin with the groups: two consisted of mixed groups of men and women problem drinkers ranging in age from the early thirties to the early fifties. Some members of the first group, which had started almost a year before the second group, continued in group therapy for a total period of 24 months. The second group met for a period of 14 months. The average regular membership in each group ranged from six to ten persons; this was true, also, of the nonalcoholic wives' group which terminated at the end of six months, according to prearranged plan. A fourth group consisting of two young married couples in their twenties met in regular group sessions over a period of three months while in concurrent individual therapy or joint therapy. One-third to one-half of each group membership were in concurrent individual therapy. Although a certain

amount of group attrition resulted from the patient leaving the group to continue with individual therapy exclusively, there were some who would not have been able to enter into and sustain an individual therapeutic relationship without the preliminary or concurrent support of the group therapy experience. Individual sessions were available on request to any members not in regular individual treatment. Such sessions were requested for the handling of stress situations when the patient felt he needed help and felt unable to wait for the next group meeting (held weekly) or felt unable to discuss something in the presence of the group. The availability of such sessions seemed to serve a particularly valid therapeutic purpose; the patient could come as near or stay as far away as he chose from closer involvement. Even the occasional, and particularly the regular concurrent, individual therapy sessions demonstrated over and over again how a piece of insight or self-understanding could be helped to "break through" as a result of the patient discussing, in individual therapy, some problem or interaction which had occurred in group therapy. It sometimes happened in reverse.

Although the therapeutic principles applicable in individual work are basically part of the group process, the multiplicity of interactions and interrelationships between the various group members and the therapist provide for additional therapeutic experience not possible in a "one-to-one" relationship, such as when one member, through identification with another member's expressed feelings, is able to be freer of his own constrictions or, in reverse, by mobilizing control of emotional liability. The group is also an excellent medium for reality testing. The group setting makes it possible, particularly with concurrent individual sessions, to observe

what is occurring psychologically and behaviorally with each member of the group with regard to: 1) individual dynamics, 2) the meaning of interaction of each member with every other member in the group, and the therapist, and 3) meaning of the group entity as a whole to each individual member.

Since the group setting offers rich opportunity for "acting out," the question may arise regarding the possibility of a group member arriving in an intoxicated state. It happened rarely, but it does occur. It can be a therapeutic experience for the person and the group. An example of this is the woman, a shy person with difficulty in expressing herself, who had had seven months of individual therapy before entering the group. One of her problems had been that of solitary drinking, which had not yet interfered with her responsible, long-time position. She had been under considerable stress and, on one occasion, drank before coming to a meeting, arriving quite intoxicated. She expressed pride at having "made it" to the meeting as well as remorse for her condition. She also expressed herself fully regarding the crisis situation which was troubling her and described her feelings regarding various members of the group. The group identified strongly with her because of their appreciation of her limited ability to express herself and accepted her and her behavior, although after her departure the group needed help in handling their reactions to the experience. In another instance, a man arrived mildly intoxicated and requested concurrent individual therapy after the meeting, which he used well, maintaining abstinence subsequently. There were good immediate therapeutic results from these two drinking episodes. It is my feeling that this kind of "acting out" behavior requires tol-

erant but firm and consistent handling. It was made clear by the therapist, both individually and in the group, that the person was accepted, the drinking was understandable in that particular instance, but that there was no approval of further drinking. Other group members made one or two comments of a testing nature regarding drinking, which were handled in the same way: namely, that drinking was not acceptable in the group. This can be conveyed, effectively, nonverbally as well as verbally.

Perhaps it is because of the severity of the personality difficulties and interpersonal relationship problems in these patients that a varied intensification of therapy appears as a possible solution. One alcoholic patient who had been receiving both group therapy and individual therapy, concurrently, seemed unable to make much progress in terms of her disturbed marital relationship. Her husband, who had also expressed interest in individual therapy, requested it with his wife's therapist in a desire to work not only on his own personal problems (he was nonalcoholic) but also on his marital problems. Such a plan was made, and later on, joint therapy with husband and wife together was added.

The timing for joint therapy was important, inasmuch as it was at this point that the husband was becoming aware of his vicarious satisfaction in the dependency needs and "acting out" behavior of the wife because of his own unresolved problems in these areas. It was not long after this that the wife's group therapy could be terminated. It was felt, in this case, that the joint therapy was chiefly responsible for the resolution of the marital difficulties because of the direct therapeutic attention to the marital relationship in the joint sessions.

Various combinations have been utilized,

with a specific goal in mind. For instance, the two young couples with anxiety about parent-child relationship problems, who met together for a three-month period, were enabled, through interaction with each other, to handle the anxiety of the two alcoholic members (a man and a woman) sufficiently to motivate them strongly to work on their disturbed marital relationships; both couples subsequently did this in joint therapy.

The use of the joint sessions has served a two-fold purpose: that in which it was the preferred form of therapy with limited goals and that of implementation to individual therapy or group therapy as described. In two instances, two couples—one in their thirties, with three children, and one in their fifties—utilized joint therapy *only* with remarkable success in a relatively short period: the first couple in a period of three months of therapy and the second in a period of six months of therapy. In both of these cases, the crux of the therapeutic interaction in the course of the joint sessions was the handling of the irrational projections and distortions of one marital partner. The unreal elements in the personality conflicts of the partner reacting in this way played the main role in disturbing the previously functioning complementarity of the marital relationship.

Nathan W. Ackerman, in "The Diagnosis of Neurotic Marital Interaction" in *Social Casework*, April, 1954, states: "The conflict between the partners" [moreover] "bears a special relationship to the structure of intrapsychic conflict in each partner. The very first question to arise is: What part of the conflict is real, what part unreal and determined by neurotic perception and motivation? Further, how does the unreal part secondarily distort the

relatively more real aspects of marital interaction?"

There appears to be increasing recognition in the literature on marital interaction by all the professional disciplines, that the disturbed marital relationship itself may not necessarily benefit, therapeutically, by either individual treatment of one partner *or* by individual treatment of both partners by different therapists working separately. The experience of therapists in this area indicates that attention to the multiple factors influencing the relationship are fundamental to the understanding of its complementarity and reciprocity of satisfactions within the relationship. As is true of the relationships in a group, the marital relationship is more than the sum of the personalities of the partners. The relationship can influence each partner, which, in turn, can change the relationship.

The criteria for selection of patients for any of the three forms of therapy, i.e., individual, group, or joint, included one or more of the following, in addition to clinical considerations: 1) awareness and recognition of need for help for self in terms of own personality problems; 2) awareness of self-involvement in marital relationship difficulties; 3) awareness of self-involvement in parent-child relationship problems. With regard to admission to group therapy, other factors were considered, such as the patient's ability to participate in a group and, particularly, his comfort or desire for comfort in expressing himself in a group. Some were more shy and isolated socially than others. The therapeutic goal, generally applicable to all three therapy forms, was better understanding of self (in the life situation) and/or better understanding of self in relation to spouse or children.

In the alcoholic groups, because of fewer current close interpersonal relationships (many were divorced, separated, or single) these people were motivated for changes within themselves and/or their behavior. With those who did maintain meaningful close relationships, there appeared to be less conscious anxiety in this area.

In the nonalcoholic wives' group, all were mothers of young children and/or teen age children. Motivating factors which all had in common, without exception, were: anxiety regarding the marital relationship and desire for help with parent-child relationship problems. In this particular group, apart from individual changes, there were some universal ones experienced by everyone (whether the husband was in treatment or not); 1) decrease or disappearance of anxiety and hostility toward alcoholic spouse; 2) increase in self-interest and in external satisfactions; 3) decrease in symbiotic relationship with spouse—seeing themselves as separate persons; 4) recognition of own dependency needs and how handled, including both met and unmet needs; 5) actual working through of some parent-child relationship problems, resulting in partial or total resolution of specific problems in the children.

By contrast, the results in the alcoholic groups were more individualized, although there were some common realizations by different persons at different periods in treatment, such as: reduction in impulsivity or emotional lability; understanding of patterns of reaction and behavior involving hostility, perfectionistic drives, self destructiveness, etc. One alcoholic patient who terminated at the end of one and one-half years of group therapy and one year of concurrent individual therapy, revealed, as gradual and increasingly adequate functioning occurred (i.e., psycho-

logical and behavioral functioning) the following change in pattern: "I have failed again—I give up—I blame my hated step-mother" to "I have succeeded—I can do it again—I understand why I hate my step-mother—I am responsible for my own behavior."

In joint therapy with married couples, there were the following positive prognostic indications in terms of the couples' ability to utilize help:

The initiation of the request for help was made in each instance by the spouse whose current "acting out" (i.e., drinking) symptom had precipitated anxiety and motivation within himself (or herself) to do something regarding his own personal problems as well as marital relationship problems. Subsequently, as predicted accurately by the applicants, their spouses were found, when interviewed, to be as interested in help for their own personality difficulties, in varying degrees, and also interested, and this primarily, in better understanding their part in the marital relationship difficulties; each spouse who had children asked for the same kind of help with regard to his relationships with his children. The nonalcoholic wives involved wondered to what extent they encouraged, consciously or unconsciously, the drinking problem of the spouse.

One of the chief values of the joint sessions appeared to be the immediate availability, through observation, of the kind of interaction which could throw light on the nature of the relationship as well as on the personalities of the marital partners. The joint interaction proved valuable diagnostically and prognostically as well as simultaneously therapeutic. The experiential nature of the verbal and nonverbal interaction shares some characteristics with both individual and group therapy.

From the patients' standpoint in joint therapy, all, without exception, expressed, aside from any attitudinal or behavioral changes, that early in the joint sessions they were able to discuss problems which they could not discuss at home because of upset and angry feelings. Much later in the sessions, they described increasing facility in communicating with each other at home, without tension in the area discussed earlier in the joint sessions, as the marital relationship became relieved of its stresses and strain. The focus here is as much, at times, on the relationship as on the individual patient and since social as well as psychological processes are involved, the resulting development of emotional communication between the partners is facilitated.

In concluding, a word should be said regarding the importance of the initial contact and/or beginning therapeutic period with the person who has a drinking problem. An attitude of acceptance and respect for the individual as a human being is important on the part of every staff member who comes in contact with the patient. In our center, which is a

multidisciplinary setting and which includes both a medical and a psychiatric clinic, it is felt that the psychological atmosphere, so to speak, is contributed to by the total staff, including the receptionist at the beginning contact. The giving to and doing for the patient, which appears to be vital initially, is represented by the giving of symptomatic medical treatment. In initial psychotherapeutic contacts, the more active (*than usual*) participation of the therapist is essential. And as all social workers know, the quality known as warmth in the personality of the therapist, is almost as, if not *as*, important as technical skill. And, finally, I would like to stress the importance of considering both the problem drinker and the relative who seek help, as human beings with just as individualized a personality and life experience as any other person who, in effect, is saying that he is unable to cope with his life situation without some help. If the alcoholism itself is seen as a symptom rather than unacceptable social or moral behavior, it is easier to find the human being who is enmeshed in its entanglements.

Ethos, existentialism and psychotherapy

Whoever treats of existentialism, no matter how he defines it, broaches the perennial problem of the soul. And the conjunction of existentialism with psychiatry connotes, to my mind, the recognition that the psyche does not equate to the soul, and also, that when psychiatry leaves the soul out of its accounts, it is in many respects inadequate and incomplete. The psyche does not equate to the soul, because the soul is laden with normative values and implications and the psyche, only with physiological ones. The psyche, man shares with all the rest of the animal kingdom—witness *animal psychology*—but the soul, at least by definition, is uniquely human.

For those ill at ease with the term "soul," I would paraphrase this affirmation in a more simple, but also more naive pattern, to wit: some among us have thus come to suspect that the full ambient of the psyche's operations, in health and in disease, cannot be conceptualized, nor realized in purely

physiological modalities, but must include also some normative components.

Also, and this is rather significant, the normative components must extend beyond the pragmatic, into the transcendental—must, in other words, relate not only to the individual's immediacies but also to the total *meaningfulness* of his embracing experience, *beyond* his individual being.

It was René Descartes, the founder of neurological psychology, who dislodged the soul and relegated it to the pineal gland. Why he elected this emplacement for the soul, no one can say precisely. But, in doing so, he initiated a divergence in psychiatric thinking from which we are only now beginning to recover. What I mean is that, with the initiation of neural psychology,

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and as a consequence, both psychology and psychiatry discarded "the soul" and replaced it with the "psuche," the psyche. Since then, the psyche, as a primary aspect of mind, and mind, as a derivative of brain structure and operation, have prevailed as the dominant, but not the universal, persuasion of psychology and psychiatry. I say dominant but not universal, because there was always a fringe group of thinkers and scientists who stubbornly resisted the seductive rationality of the Cartesian *Méthode*, being persuaded that there was more to the psyche, and vastly more to the soul, than a labyrinth of reflex arcs dominated by a mass of gray matter.

Interestingly enough, it was one of the great pioneers of modern science, Paracelsus, who headed this recalcitrant group. The line of his unorthodox orientation can be traced through a host of men, from Stahl, through to Mesmer, and from the Naturphilosophs of the Romantic period, down to Freud.

Freud, on every possible occasion, affirmed his allegiance to nineteenth century science. In effect, however, he breached the science of his natal century. Unconfessed, and most likely unwittingly, he had a greater affinity for the Romantics and the Paracelsians than he had for the mechanist-materialist school of his own age, for, say, DuBois-Raymond and Brucke.

The essential historical facts are that Freud structured his psychiatry, his metapsychology, and his psychotherapy not on a foundation of neurons, reflex arcs, association centers, and so on, but rather on the basis of instincts, primal drives, repressions, sublimations, transpositions, etc., all of which, according to Freud, are ultimately reflected in the interrelationship of Ego, Id, and Superego. By this formulation, Freud lifted psychiatry out of its low ontological level and raised it to a plane where

once again one might view mind and psyche in the ambient of the soul.

Seen in the perspective of our consideration, the cardinal contribution made by Freud lies in this: that he brought into our awareness the existence and operation of an intrapsychic concatenation of energetic quanta, which he termed Id, Ego, and Superego, and which are, except at the vital level, neither dependent upon, nor explicable by, physics and chemistry—simple matter and simple energy. His was, therefore, not a science of things but one of relationships.

Freud revolutionized psychiatry, but he encountered much difficulty in defining his tripart energetic quanta: the Id, Ego, and Superego. The one that gave him the greatest trouble, and where he went most astray, was the Superego.

Freud traced the origin of the Superego to the inhibiting injunctions imposed on the child by the parent and to the other supplementary, socializing taboos and prohibitions which society imposes upon the individual. One need not subscribe to Freud's mythological rendition of the Oedipal complex, with its infantile incest wish, castration fear, etc., to appreciate that, in this formulation, Freud extended the encompassment of his psychoanalysis beyond the confines of a purely intrapsychic science, to embrace, in its most limited confines, the familial constellation. The individual is indeed the terrain in which the contest is waged, but the protagonists may be, and indeed are, extraneous and alien to the native person. Only the Id is given; the Ego is acquired; the Superego is imposed.

In the early days, psychoanalysis was fixated to "the individual on the couch." It was not long, however, before the disciples and followers of Freud became aware of the restrictive limitations of this fixation. They broadened their concerns, perceiving

that man does not live alone *even within himself*. He is never self-made. He is embedded within a social matrix, the first perimeter of which is the family group. More remote, but not less potent, is the community and the more extensive social, economic, and cultural aggregate.

One of the most significant episodes in the development of psychoanalytic theory was the discovery of the character neurosis. This discovery stands to the credit of the late, and to be lamented, Wilhelm Reich although others, notably Franz Alexander and Nunberg, shared in its exposition and illumination. This discovery cut squarely across Freud's basic theory of the etiology of the psychoneurosis. The psychoneurosis, according to Freud, derived from repression. The Ego was, so to say, caught in a squeeze-play with the Id drives on one side and the Superego on the other. But here were the character neurosis-revealing, instinct-driven individuals in whom the Superego was either missing or, if present, nonoperative.

In such cases, and they are very numerous in contemporary society, there are no Freudian repressions apparent and none to be conjured up from the depths of the unconscious by the necromancy of "free association" for these are not cases of repression but rather of *deprivation*.

The recognition of the character neurosis served to extend the interests of analysts and analytically oriented psychiatrists beyond the purely intrapsychic phenomena to the psychological dynamics of group relationship, within and beyond the family.

In connection with these developments, a few names come to mind: the Swiss, Maeder, one of the early co-workers of Freud, Alfred Adler, Trigant Burrows, an American whose work has been sadly neglected, Harry Stack Sullivan, William Healy, and Franz Alexander; also, Bernard Glueck,

who must be counted a pioneer in this field, David Levy, Paul Schilder, Nathan Ackerman, Melanie Klein, and Anna Freud. These and others, too, began to ask questions, not only as to *what* the family *is* and *how* it *operates*, but, also, what it is *for*, that is, what sociocultural, psychological purpose it subserves.

These inquiries soon made it clear that the family, no more than the individual, operates in *abstracto*, that is, as a purely psychological dynamism. The qualities and the dimensions of the objective world impinge upon and penetrate into its very substance and affect its character. It is thus, too, that sociologists, economists, and cultural anthropologists have entered upon, and have made, numerous, valuable, and illuminating contributions to the academic and informational knowledge of psychiatry and psychoanalysis.

By all this, it can be seen that we have come a long way from the Cartesian, anatomic-physiologic concept of mind and psyche. To neural structure and function have been added the perspectives and dimensions of ecology, group dynamics, economics, and social culture. The psyche is no longer conceptualized as an epiphenomenon of brain and mind; nor is psychotherapy envisaged as essentially an intrapsychic reorientation.

Currently, we are on the threshold of a new "quantum phenomenon," the transition from the perimeter of the "psyche" to that of the "soul." This "quantum phenomenon" is represented in Europe by the psychiatric preoccupation with "existentialism." In America, I would identify it with the intensive effort to reconcile religion and psychiatry.

Existentialism, as a form of emotional and philosophical orientation, has not, and, in my judgment, is not likely to take root in the United States. Neither the "soil of

experience" nor the "climate of opinion" favor its enracination. But we will come to to the same goal by a different route.

The reason for this, as I see it, is that the North American people have not been exposed to, nor afflicted with, the heavy burdens of disaster, wars, revolutions, and the failures of sociocultural institutions to which the European peoples have been subjected during the past two centuries. We in America have a primal, instinctual faith in life and in life's experience. It is no doubt naive, but there it is.

And yet we, quite like the European existentialist, are in quest of the soul. Our quest is motivated by individual experience; Europe's, by the collective experience. We both, however, grope for an answer to the question: human existence, what is it for; what meaning is there to man's life?

The existentialist has seemingly come up with an answer, or rather with a variety of answers, for there are many varieties of existentialism. We in the United States have only *tentatives* and no answers. We study the European existentialists, from Kierkegaard to Binswanger, Heidegger, and Sartre, and we listen to Paul Tillich, Martin Buber, and Jacques Maritain.

But, I am less impressed by the answers proffered than enthused by the questions asked, for in them I perceive that psychiatry has finally recognized the "normative prerequisites" essential to its own maturation.

Freud affirmed that analysis offered no *Weltanschauung*, no view of life and living. Some have interpreted this to mean that psychoanalysis is utterly indifferent to the value systems of the prevailing ethos—the gauge that differentiates between that considered to be good, decent, and lawful, and its opposites. In so far as every ethos is cluttered with petty, tyrannical, and irrational moralizing, Freud and his interpreters are correct and warranted. Neither psychoa-

alysis nor psychiatry can be entirely oriented to, nor serve as, the defenders of the status quo.

But, at the core of every ethos, there is the residual and irreducible question: what is life for; what is life; what is the meaning of man's existence? To this problem every sensitive and thinking man must direct his mind and spirit and somehow forge an answer. The answer of some is a denial of the validity of the question. With others, it is existentialism. To still others, it is the affirmation of the soul. These last see man as a time- and space-bound conglomeration of matter, suspended between the eternities of the past and of the future and serving to bind them together in his own being and in his own existence.

You gather, I am sure, that I inscribe myself in the third group. But I will not abuse your patience by arguing in its favor. I must, however, comment, be it ever so briefly, on the other answers. The man who denies the validity of the question "what is the meaning of man's existence?" most commonly, in his everyday life, denies his denial. He does not live a meaningless life. On the contrary, most often his life is charged with intense devotions. His life is suffused with meaning, but he fears to formulate it. He belongs to that order of man whom I label "facto-phile and ideaphobe."

Of existentialism as an answer to the problem of the meaning of human life, it is difficult to speak definitively, for under the banner of existentialism march a host of faiths, a motley of persuasions. At its lowest levels, existentialism appears as a philosophy of desperation. "Since we are entrapped in existence, let us make existence itself the rationale and warrant for existence." This counsel of despair does not even have the heroic-Promethean overtones of Nietzsche's "Affirmation of Life" nor the

hedonic suavity of Omar's song: "Let us live today, for tomorrow we die."

At its highest levels, as expounded by Tillich, Buber, and Maritain, existentialism sounds suspiciously like a refinement of old theological issues. I do not object to this, but I do wonder, why the new label? Is this existentialism anything but a further grappling with the Jobian problem? Is it not, in effect, an addendum to the Book of Job, formulated in the light of our better knowledge of Man, the Universe, and the psychic dynamics of human culture? Is this not, in effect, an advance in our understanding of the soul?

Here, as you see, the soul crops up again! Many among our contemporaries are shy of the very term "the soul" and with very good warrant, too. For the soul has been, so to say, pre-empted by the theologians, who have attributed to it a variety of attributes suited not to the soul but to their own parochial needs and interests. But the soul is not the patented property of religion. It is reasonable to believe that the soul was an anthropological entity long before religions ever were formulated. It was, in fact, the forerunner and the progenitor of religion.

To understand the soul in the context of psychiatry, one must view it in its anthropological perspective. Then it becomes patent that, in the sporting adventuresomeness of primal creativity, nature spawned one creature among its millions that had the potential "to treat of meaning." *When* that took place, we do not as yet know. It may have been a half million years ago; it may have been 10 million years ago. More assured is the fact that this creature, who first perceived "meaning" in stick and stone, thus creating tools and weapons, has never since ceased to search for meaning in each and every phase of its being and existence.

It thus earned for itself the name *Homo sapiens*.

It was many, many thousands of years ago that this inquisitive and inquiring creature perceived that it could not find self-fulfillment within the confines of its own being, that it needed and wanted the *others*. That perception we now term "altruism." In the birth of that perception, the "soul potential" became the "soul operational."

The need for others has become, with the passing of the millenia, more embracing, deeper, and more refined. Two of its most subtle manifestations are the recording and the study of history and the perennial projection of Utopias.

Religion, as the structured and institutionalized guardian of man's altruistic knowledge and faith, is of comparatively recent origin.

I need not catalogue for you the deleterious effects that are and have been the by-products of this institutionalizing process. I can only paraphrase for you Lord Acton's words, to affirm that all institutions corrupt, and the absolute ones corrupt the most. But on the other hand, man, as man, cannot exist without institutionalizing his experience. Here, then, it is not a matter of *doing away with* but of *rectification*.

But, on the score of all this, one might ask: "Is it really necessary to drag the soul into this argument; could it not be left out?" To which my response would be: "In name, *yes*, in essence *no*," and I see no profit in calling the soul by any other name. On the contrary, I see a loss in the breach of the historic continuity of designating the soul as the soul.

Then it has been suggested that it were better to leave all consideration of the soul to those whose business and devotion it is to care *about* and *for* the soul. This, I am willing to grant, but, to my mind, this group includes the psychiatrist. He, too, must care

about and for the soul. Why? Because effective psychiatry must be normative.

I'll not reiterate my argument, but rather end on a practical consideration. Psychiatry, which was for long the hysterics' need and luxury, has become a common necessity in contemporary society. The type and order of patient we see today, both in and outside of the institutional setting, is radically different from the patients treated by Freud and his contemporaries. More and more we see unhappy and inwardly ineffective individuals who cannot be fitted into any of the categories of classical nosography.

The sociologists recognize these people even better than we do and call them the "Lonely Crowd," "the Outsiders," "the Disinherited." These are sick people, and their number is legion. *We* cannot treat them all as patients. But we as psychiatrists can contribute, and I underscore *contribute*, to the amelioration of their plight—this, by helping to change the Ethos in which these people and we, too, live and operate. But, first of all, we ourselves need to understand the historic-anthropologic foundation and emergence of our Ethos, wherein the soul is the effulgent core.

Controversial issues in the management of drug addiction: legalization, ambulatory treatment and the British system

This paper will be devoted to a discussion of several interrelated and highly controversial issues concerned with the management of the drug addiction problem, namely, legalization, ambulatory treatment, and the so-called "British system." Supported by the fashionable cult of permissiveness in the handling of the behavior disorders, the advocates of the latter proposals have made surprising headway in recent years in converting such important professional organizations as the American Medical Association, the American Bar Association, and the New York Academy of Medicine (10) to their point of view. Their general strategy is to represent *all* opponents of their approach as favoring a punitive approach to the treatment and prevention of drug addiction.

CRIMINALITY

Except for representatives of certain law enforcement agencies, practically everyone concerned with the problem believes that

drug addiction, like alcoholism, is a disease requiring treatment rather than a crime requiring punishment. Among psychiatrists, psychologists, sociologists, and even many jurists, the criminality of drug addiction is no longer a serious issue, despite the efforts of permissive extremists to portray everyone opposed to ambulatory treatment and legalization as believing that drug addicts are immoral and vicious criminals. Technically speaking, of course, drug addiction *per se* is not a crime. But since all drug addicts are guilty of unlawful possession, sale, or purchase of drugs, or of illegal diversion of legitimate stocks for personal use, drug addiction, for all practical purposes, is a criminal offense.

The present legal status of drug addic-

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tion as a crime, in effect (if not according to the letter of the law), is an unfortunate social anachronism. When the first federal hospital for the treatment of drug addiction was established in 1935, the U. S. Public Health Service regretfully went along with the proposal to retain the criminal status of acts associated with the practice, in the mistaken belief that only in this way could compulsory treatment, a drug-free therapeutic environment, and adequate supervision of the released addict be ensured. Actually, all three aspects of treatment could be satisfactorily accomplished, without making drug addiction a crime, by requiring mandatory hospital commitment of all addicts, including those who voluntarily commit themselves.

Many unfortunate consequences have resulted from this legal anachronism. The federal drug addiction hospital has acquired an unmistakable prison atmosphere which not only subtly influences the attitudes of physicians and attendants toward the patients but also focuses undue attention on the security and custodial aspects of treatment. Little hope for attitudinal improvement can be anticipated when society adopts a punitive approach toward victims of a behavior disorder and treats them as criminals. The illegal status of drug addiction increases its attractiveness for antisocial psychopaths and for aggressively minded adolescents temporarily alienated from the norms of the adult world. The social stigma attached to ex-convicts also impedes the rehabilitation of treated drug addicts when they return to the community and discourages parents from seeking the help of courts and social agencies for their addicted adolescent children.

Addicts are also implicated in crime apart from the fact that they possess drugs illegally. The cost of illicit drugs is so high that only upper-class addicts can support

their habits without earning money dishonestly. Most addicts are obliged to turn to such remunerative forms of crime as shoplifting, housebreaking, confidence games, and drug peddling. Such criminal activity, however, is largely incidental or secondary to addiction and is not indicative of deep-seated delinquent trends. This is shown by the fact that most addicts have no history of criminal involvement prior to addiction (12). The figure of 25 per cent who *do* have preaddiction criminal records is not excessively high for a population that is largely slum-urban. Addiction, furthermore, reduces "both the inclination to violent crime and the capacity to engage in sophisticated types of crime requiring much planning" (3). In the light of serious extenuating circumstances, it is inexcusable for society not to make reasonable allowances for criminal acts following from addiction and not to differentiate between addict and nonaddict drug peddlers.

To regard drug addiction as a behavior disorder rather than as a crime does not mean, however, that society must refrain from making any evaluative judgments regarding the practice. The mere fact that a drug is used habitually is not necessarily a bad thing. But when the habitual use of certain drugs happens to be detrimental to the well-being of both the individual and society, it must be regarded as a pernicious vice. It has been unequivocally demonstrated that opiate addiction, in the overwhelming majority of cases, interferes with the productivity of work, with the desire for real achievement, and with mature, responsible adjustment to problems of vocational, family, social, and heterosexual adjustment. Historical experience in China, Egypt, and other Eastern countries has also shown that drug addiction is a major contributory factor in perpetuating poverty, famine, disease, ignorance, and lack of social

and economic progress. Hence, society has a moral right and duty to suppress drug addiction, both to protect itself and to prevent the individual from inflicting harm on himself.

It should be perfectly clear, therefore, that a marked difference exists between not regarding drug addiction as a crime and allowing individuals unrestricted or legal access to drugs. There is nothing immoral or criminal about drug addiction, but it is highly immoral for society to take a permissive attitude towards a practice so completely destructive of individual and social welfare. The potentially ruinous consequences of large-scale addiction are so great that control of narcotic drugs cannot simply be left to the discretion of the medical profession. Widespread abuses associated with the prescription of barbiturates and tranquilizers are indication enough of what would happen if strict legal controls were removed from the dispensing of narcotics.

LEGALIZATION

This brings us to the proposals of those who favor ambulatory treatment and legalization. Their thesis is simply this: The present system of legal controls constitutes the primary cause of drug addiction by creating the possibility of making fabulous profits in an illicit drug market. "Profit," states the Subcommittee on Drug Addiction of the New York Academy of Medicine, is "the principle factor" in drug addiction. Hence, "the most effective way to eradicate drug addiction is to take the profit out of the illicit drug traffic" (10). One does this by treating drug addicts on an ambulatory basis in outpatient clinics or in physicians' offices. Addicts who are prepared to undergo withdrawal treatment immediately are so treated, but addicts who are not ready for such treatment are given supportive therapy and provided with drugs until such

time as they can be persuaded gradually to give them up. "Incurable addicts" (i.e., those permanently refractory to treatment) on the other hand, are provided with a minimum maintenance dose for the rest of their lives. In this way, since drugs are legally accessible to all addicts at cost, the illegal drug traffic vanishes and, with it, the profit motive that causes addiction. Drug addicts are no longer obliged to turn to crime to support their habits and can lead normal, productive lives. This attractive plan would be quite convincing if it were not based on at least 15 identifiable, logical fallacies and errors of fact.

First, the assertion that the profit motive is the primary cause of drug addiction is excellent Marxism but poor psychology, bad sociology, and worse logic. It is also in direct contradiction to incontrovertible historical facts. No one denies that the international drug cartel is highly motivated to perpetuate the illicit narcotics traffic and to maintain its astronomical profits. But, although these motivations undoubtedly contribute to the complex chain of events associated with the causation of drug addiction, only two indispensable factors are necessary for the development of the drug habit: (a) the existence of addiction-prone personalities in a tolerant social environment and (b) the availability of narcotics. If these two conditions exist, there will always be drug addicts, irrespective of whether heroin is sold illicitly at two dollars or legally at two cents per capsule. How do we know this? Simply by the fact that prior to the passage of the Harrison Narcotic Act in 1914, when there was no illicit market and narcotics could be bought for pennies over the counter, the rate of drug addiction was five to eight times the current rate (6). Thus, if we removed all legal restraints and thereby managed to eliminate the illicit trade in narcotics, there is every

reason to believe that the population of drug addicts would be increased at least fivefold. I earnestly believe that effective law enforcement measures on an international scale could practically eradicate the drug traffic. If I had to choose between the two evils, however, I would much rather settle for an illegal market catering to 80,000 addicts than a legal market supplying 400,000 addicts.

Second, the expectation that giving addicts legally a minimum maintenance dose would destroy the illicit market is incredibly naive and based on lack of understanding of the psychology and pharmacology of opiate addiction. Since the vast majority of seriously disturbed addicts take opiates for their euphoric effects and since tolerance for these euphoric effects is acquired very quickly, few addicts would be satisfied with the small dosage required to prevent withdrawal symptoms. Unless they received legally as high a dose as they needed to obtain their euphoria, addicts would continue to purchase most of their narcotics on the illicit market and would continue their criminal careers to obtain the money to do so. That legal provision does not eliminate illegal traffic is clear not only from our own American experience with ambulatory clinics after World War I (14), but also from the experience of China and other Asian countries with serious addiction problems (8) and of such Western nations as Sweden and Great Britain with relatively minor problems (7).

Third, the distribution of legal drugs to addicts would probably increase the illicit traffic in narcotics by adding to the total amount of drugs in illicit channels and by removing whatever deterrent value lies in the fear of the abstinence syndrome. Always sure of the minimal dose necessary to prevent withdrawal symptoms, addicts would have little immediate incentive to

seek a cure, and nonaddict users and potential addicts would perceive fewer hazards in addiction.

Fourth, even if established addicts received as high a dosage as they craved from physicians, the existence of a large number of potential addicts in vulnerable neighborhoods would still make black market operations in narcotics economically feasible.

Fifth, there is nothing punitive about an approach to prevention that seeks to reduce the availability of narcotic drugs. Isolation of disease-producing agents from susceptible individuals is one of the oldest and most reputable public health procedures known to medicine. It is the major preventive principle used in controlling such diverse diseases as typhoid fever, lead poisoning, botulism, malaria, and amoebic dysentery. No matter how many addiction-prone persons circulate among us, not one can become addicted unless he has access to narcotics; and, with respect to diseases for which there are no known or reliable cures, surely the best and only safeguard available to both the individual and society is effective prevention. The rate of addiction everywhere is highly related to the availability of narcotic drugs. It is the lowest in those states where law enforcement is most stringent (1) and is highest in those professions in which access to narcotics is easiest (9). In England, for example, the rate of addiction is approximately 55 times as high among the medical and allied professions as in the general population (4). Vigorous enforcement measures in China prior to World War II markedly reduced the magnitude of the addiction problem (8), and in our own country, the reduced availability of illicit drugs during World War II was correlated with a dramatic fall in the rate of addiction (9).

Sixth, the assertion that the Harrison Narcotic Act has not only failed to reduce

the incidence of addiction but has also been responsible for the spread of the practice is palpably false. Although drug addiction rates are admittedly only crude estimates of absolute incidence, when calculated by comparable methods they yield reliable evidence of relative incidence trends over a period of years. Despite the fact that the crime rate is currently growing four times as rapidly as the American population, the estimated rate of addiction has declined from one in 400 in 1914 (6) to a current rate of one in 3,000 (2). The rejection rate for military service on the grounds of drug addiction declined by a similar proportion from World War I to World War II. Corroborative evidence is found in the fact that the cost of illicit narcotics has increased sharply during the same period, while drug habits have decreased in size, and the potency of the drug itself has been progressively diluted.

The proponents of legalization invariably argue that in as much as we still have more drug addicts than any other Western nation after 40 years of law enforcement, legal control is futile and should be replaced by legal distribution of narcotics to addicts. This is sheer sophistry because the United States has *always* had a more serious addiction problem than any other Western country with the possible exception of Canada, and, as just pointed out, the rate of addiction in the United States has decreased almost 800 per cent since legal controls were instituted. It would be just as logical to maintain that the malaria prevention program in Mexico is a failure because the Mexican malarial rate is still incomparably higher than in Canada, and that the prevention program is the cause of the higher rate in Mexico since Mexico has a program, and Canada does not. Or one might argue with equal logic that since jewel robberies still occur today, the law against theft

should be repealed, and the Government should operate clinics to dispense jewels free of charge to known jewel thieves. That drug addiction still occurs despite reduction of drug availability simply means: (a) that variables other than availability affect the rate of addiction and (b) that no single aspect of a prevention program is foolproof.

Seventh, the advocates of legalization maintain that the illegality of drug use accounts for its appeal to adolescents, and hence that repeal of restrictive laws would cause narcotics to lose their glamour in the eyes of young persons. Although the illegality of the practice undoubtedly enhances its attractiveness to antisocial psychopaths and aggressive adolescents at odds with the norms of conventional society, it greatly oversimplifies matters to attribute all of the glamour of drugs to their unlawful status. Alcohol, cigarettes, cosmetics, and automobiles are not illegal and still hold great fascination for teen-agers.

Eighth, the belief that addicts whose drug demands are satisfied lead "otherwise normal and productive lives" is based on a myth which applies at most to a tiny fraction of the total addict population: namely, successful professional persons, usually physicians, who take small doses to relieve anxiety. Most of these individuals have long since switched to tranquilizers which are both more efficient for the purpose and not proscribed by law. The typical drug-satiated addict is lethargic, semi-somnolent, undependable, devoid of ambition, and preoccupied with grandiose fantasies (16). He loses all desire for socially productive work and exhibits little interest in food, sex, companionship, family ties, or recreation, and lives mainly in the euphoric glow of his last dose and in anticipation of his next one (16). The so-called "push" which he attributes to the influence of the drug becomes evident only when his drug supply

runs out or is threatened. His belief that he can work more efficiently under the influence of narcotics is merely an illusion created by the euphoria he experiences with drug usage. Even addicted physicians who use small doses tend to become erratic and irresponsible and to manifest "don't give a damn" attitudes in clinical practice.

Ninth, the addict who receives drugs legally either for the gratification of his addiction or as part of ambulatory withdrawal therapy is not only free to patronize the illicit market but is also in a position to introduce the habit to other addiction-prone individuals. Ecological studies have demonstrated beyond doubt that addiction is spread principally by direct social contact of addicts with vulnerable nonaddicts (13), not by pushers or as a by-product of the treatment of medical conditions with narcotics. To support his habit, the drug addict also commits a substantial proportion of all the reported crimes in the nation. It is essential, therefore, to employ another well-established public health procedure, i.e., quarantine, to prevent the spread of addiction and the crime associated with it. Hence, active addicts should only be treated in institutions where they can be effectively isolated from nonaddicts. The prognosis of such treatment is admittedly poor at the present time, but even a recovery rate of 25 per cent is better than a defeatist approach that seeks to treat addicts by providing them indefinitely with drugs. It must also be appreciated that one important reason for the poor prognosis in institutions such as the USPHS Hospital in Lexington is the lack of really adequate psychotherapy, vocational training, and vocational guidance, and the complete absence of adequate follow-up services in the community once the patient leaves the hospital. Truly incurable addicts are less dangerous to society when incarcerated for life on narcotic farms

than when provided with a maintenance dose of drugs and left free to deal in the illicit market, to spread the drug habit, and to prey upon the public.

Lastly, legalization would give drug addiction an unfortunate modicum of moral sanction that would encourage its spread among potential addicts. It is argued, of course, that the imposition of legal restrictions on socially disapproved commodities is self-defeating because they are not only circumvented by black market operations but also give rise to all of the undesirable correlates of a racket. By the same logic, however, one should advocate licensing of houses of prostitution by the health department.

AMBULATORY TREATMENT

We may now consider the various reasons that render voluntary ambulatory treatment of drug addiction in the United States both impracticable and dangerous. First, although coercion—even in the form of hospital commitment—does have certain undesirable implications, it is absolutely essential to ensure the adequately controlled and prolonged treatment prerequisite for cure. Because of the tremendously efficient adjustive value of narcotics for inadequate personalities, the typical addict cannot be relied upon either to initiate or to complete treatment voluntarily as long as he is free to dabble in the illicit market. His judgment can hardly be trusted in view of his immaturity, his inability to tolerate discomfort or forego immediate hedonistic satisfactions, his predominantly favorable attitude towards drugs, and the well-known fact that the euphoric effects of narcotics are heightened when administered during withdrawal (16).

The impracticability of voluntary treatment is highlighted by its notable failure wherever attempted. Remarkably few

addict physicians spontaneously try to cure themselves despite having narcotics available for self-administered withdrawal therapy. Both the Detroit (17) and the Chicago (5) voluntary outpatient clinics attracted only a relative handful of clients, and those few who did attend were apathetic, weakly motivated, unreliable, and irregular in keeping appointments (5, 17). At the Lexington Hospital, 75 per cent of the voluntary patients fail to remain for the recommended minimum period of four-and-one half months, and of these, half leave within 30 days (9).

Second, a certain minimal degree of sincerity and good faith is necessary in breaking any habit. In the case of the drug habit, this may be defined as willingness to undergo withdrawal therapy since one obviously cannot quit using drugs while insisting on taking them. One does not give up smoking cigarettes by continuing to smoke a pack a day. Even Addicts Anonymous only accepts members who are off drugs. Yet, notwithstanding the known compulsive nature of the disorder, some permissive psychotherapists (11) advocate the provision of narcotics to drug addicts until they "feel ready" to undergo withdrawal. If an individual is unable or unwilling to impose his own controls in relation to behavior that is either self-destructive or socially dangerous, then society must impose external controls. Does one distribute matches and gasoline to active pyromaniacs and permit them each to burn one apartment house per day while undergoing treatment?

Third, it is virtually impossible to conduct withdrawal therapy successfully unless addicts are committed to special hospitals that can guarantee a drug-free therapeutic environment. It is utterly naive to expect addicts treated on an ambulatory basis voluntarily to adhere to a withdrawal

schedule, when even those addicts who voluntarily seek hospitalization almost invariably try to smuggle drugs into the hospital. Also, without continuous observation by trained personnel in a controlled clinical setting, how can proper dosage schedules be determined? Ambulatory treatment, furthermore, requires either that clients report four or five times daily for injections or that they be given drugs for self-administration. The first procedure is unwieldy and incompatible with normal vocational and family existence, and the second procedure is hazardous. Addicts may hoard or sell their daily ration or inject it intravenously.

Fourth, most physicians do not have the professional training necessary to diagnose and treat drug addiction on any basis. Apart from the relative handful of physicians trained in the two federal drug addiction hospitals and other similar institutions, medically and psychiatrically trained personnel in the United States would be at a complete loss in coping with drug addicts.

Finally, the prognosis for social rehabilitation is incomparably better when treated addicts are off drugs in view of the known deleterious effects of narcotics on their drives, interests, ambitions, responsibility, and vocational productivity.

THE BRITISH SYSTEM

As if these issues were not already sufficiently complicated, the proponents of legalization and ambulatory treatment have muddied the waters further by injecting the farfetched analogy of the British system into their arguments. Legally, the British system is very similar to our own. As in the United States, drug addiction per se is not a crime, but illegal possession of drugs is, and physicians are prohibited from prescribing narcotics to addicts solely for the gratification of their

addiction but may give them drugs in the course of withdrawal treatment or apart from withdrawal therapy if such therapy is medically dangerous. The British system, however, has an interpretive joker in it which in practice legalizes lifelong addiction for addicts without appearing to do so in a statutory sense. The Dangerous Drugs Act of 1920 is presently interpreted so that narcotics may be legally administered to addicts by physicians "where it has been . . . demonstrated that the patient, while capable of leading a useful and relatively normal life when a certain minimum dose is repeatedly administered, becomes incapable of this when the drug is entirely discontinued" (7). In effect, this interpretation enables physicians legally to supply addicts with enough narcotics to gratify their euphoric needs, since the authorities demand no proof that the addicts in question are leading normal and useful lives or that the drug is essential and is given in the minimum dose necessary for this purpose. The deliberate ambiguity of this legalistic dodge kills many birds with a single stone: British addicts are kept happy and out of mischief; the illicit market in drugs is undermined; the government has an inexpensive way of handling and keeping track of the addict population; physicians receive a government subsidy for writing narcotics prescriptions; and, above all, the government is able to maintain the legal fiction that drug addiction is officially proscribed and thereby live up to its international commitments in this regard.

Although this practice is the epitome of amoral expediency, it apparently has not led to widespread addiction even though the figure of only 359 addicts in the entire British Isles (15) is too small to be credible, and the high per capita consumption of legal narcotics suggests the existence of much masked addiction. The British are

able to get away with this system without creating an army of new drug addicts because the existing rate of drug addiction is low and there are many fewer potential addicts than in the United States. Since drug addicts are generally able to obtain legally as high a dose as they desire and since the number of potential customers is too small in any case to justify the risks involved, the illicit traffic is held to a minimum. Because of the much greater number of active and potential addicts in the United States, however, the adoption of the British system would soon create a half-million new addicts without eradicating the illicit market.

The principal logical fallacy committed by those who advocate the exportation of the British system to the United States is to impute a causal connection between the method of control currently employed and the relatively low rate of addiction. Actually, no such connection exists because the addition rate has *always* been incomparably lower in Europe than in the United States, both before and after the passage of the Dangerous Drugs Act. In the absence of definitive evidence, we can only speculate why this is so. For one thing, as shown by her much lower rates of divorce, alcoholism and major crime, Britain has a sociologically more stable culture than the United States. For another, Britain does not have large, culturally unassimilated, and underprivileged racial minority groups living under slum-urban conditions. Only 0.2 per cent of of the population of the United Kingdom is of non-Caucasian stock as compared to 16 per cent of the American population. The significance of this difference lies in the fact that two-thirds of the addict population of the United States is recruited from the latter 16 per cent (1).

Thus, it would be more reasonable to

conclude that the low rate of addiction in the United Kingdom exists despite rather than because of the British system, and that if this system were substituted for more stringent methods of control in countries where the population is more vulnerable to drug abuse, it would greatly increase the incidence of addiction. In this connection it is instructive to note that the over 13,000 addicts (15) reported by Hong Kong, a British Crown Colony, during 1957 gave that colony an addiction rate 22 times higher than that of the United States (15). One might imagine that persons advocating the exportation of social or other practices from one country to another would first consider comparability of relevant conditions. Clothing suitable for the North Pole is quite appropriate for South Polar conditions but is hardly suitable for South Carolina.

SUMMARY AND CONCLUSIONS

Drug addiction, like alcoholism, is a disease requiring treatment rather than a crime requiring punishment. The current punitive approach to drug addiction is incompatible with modern concepts of treating and rehabilitating the victims of a personality disorder. Nevertheless, since drug addiction is incontrovertibly destructive of individual and social welfare, it is highly immoral for society to adopt a permissive attitude towards the practice such as is implicit in legalization.

The assertion that legalization of addiction would eradicate the practice by taking the profit out of the illicit drug traffic is not very convincing, because prior to the existence of the illicit market, when narcotics were sold over the counter, the rate of drug addiction was eight times higher than the present rate. It is unlikely, in any case, that legalization would even eradicate the illicit traffic. Since most

addicts use drugs for their euphoric effects, they would not be satisfied with maintenance doses and would purchase supplementary amounts illegally. Addicts on drugs not only do not lead normal and productive lives but also spread the practice to other vulnerable persons and prey on the general public to support their habits.

Voluntary ambulatory therapy is thoroughly impractical. Compulsion is essential because addicts cannot be relied upon either to initiate or complete treatment. It is also impossible to ensure adherence to withdrawal schedules unless patients are under continuous observation in a controlled, drug-free environment. Provision of drugs for self-administration is self-evidently hazardous whereas multiple daily visits to a clinic are therapeutically unfeasible.

The British system legalizes, in effect, the distribution of narcotics to addicts for the gratification of their euphoric needs. Although amoral and expedient in approach, it does not result in large-scale addiction because the number of both active and potential addicts is incomparably smaller than in the United States. A low rate of addiction, however, has always existed in Britain and is not causally related to the British method of control. If adopted in the United States, the British system would undoubtedly multiply the existing number of addicts.

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FRED CUTTER, Ph.D.

Patient-led discussion groups in a state hospital

The concept of patients helping other patients is an old one. However, the systematic use of patients as group leaders, in an effort to help other patients work through their disturbed feelings, is relatively new. The classical outlook assumes that all therapy stems from staff. Patients are seen to be passive recipients of "good" with peers as competitors for staff time. Actually, effective staff-led therapy presumes the good will, co-operation, and interest of the patients. Patient help in the laundry and kitchen has long been considered appropriate and even therapeutic.

Is it not equally appropriate and therapeutic to utilize patient help in facilitating peer patient self-expression, understanding, and better reality testing? The approach suggested by the writer assumes that each patient has a potentiality for good in terms of social rehabilitation. The use of patient group leaders to supplement the therapeutic

activities available for patients is an evolution in the concept of the treatment setting, an evolution that moves in the direction of the increasing use of patient initiative, energy, and good will (11).

At Atascadero State Hospital, a tradition has developed in which the principle of mutual help and acceptance is central. This tradition is manifested in terms of patient government, staff-led group therapy, and co-operative activities aimed at improvement of the patient community: e.g., patient newsletter; car pools for visitors; information and public relations with relatives, judiciary, and professional personnel; patient recreation and entertainment, finan-

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cial assistance, mutual education, etc. (1, pp. 17-20). Patient-led discussion groups are one of the efforts made by the patients to help each other. Like most of the patient activities, patient-led groups are an effort to meet a need.

When sex psychopaths were first admitted for treatment at Metropolitan State Hospital, the shortage of trained staff produced an acute need for staff-conducted therapy. The presence of nonpsychotic patients permitted the use of patient leaders as one possible solution. Subsequently, patient-led discussion groups have existed at Atascadero State Hospital since its opening over four years ago (10). Currently, there exists a sufficient number of professional staff to permit the assignment of a therapist (physician, social worker, or psychologist) to every sexual psychopath committed to the hospital.

Good group leadership requires many and varied qualities. Some minimal common denominators are: an accepting manner, personal security sufficient to permit group process to run its course (even when the leader is verbally attacked) and subsequently to be able to make use of any group consensus that occurs, and the ability to focus group attention on pathological behavior. A fourth quality differentiates the trained from the untrained group leader; this quality refers to the body of knowledge called psychodynamics and psychopathology. Such knowledge is usually obtained by academic education, on-the-job training, and personal experiences. The absence of this knowledge limits the helpfulness of patient-led groups and restricts them to a "supplementary" role. Nevertheless, it must be stressed that technical knowledge will not replace a humane acceptance and therapeutic optimism toward individual patients (6).

By "supplementary," the writer has reference to certain natural advantages that patients have over nonpatients by the nature of their disorders. Thus, patients are potentially more sensitive to problems in others, which they themselves are experiencing. Given the atmosphere of acceptance and mutual involvement that obtains in small groups, the patients are usually able to utilize their sensitivity in a socially helpful rather than a defensive manner. Associated with such an interest is the effort to seek improvement of a peer with a similar interpersonal problem because of the identifications which develop in the course of hospitalization. Patients have more time and energy, which, together with more intense interests in a peer patient, permit a more extensive—albeit blundering—kind of working through of morbid feelings, in comparison with staff effort. The supplementary working through of these feelings tends to permit the staff therapist to move faster in his efforts to uncover deeper or additional areas of disturbance.

However valuable the foregoing may be, by far the most vital role filled by patient-led discussion groups is the mutual support which is always forthcoming in the event of a crisis. The danger of a psychotic break, precipitated by patients, staff, or life, is minimized by the omnipresent reassurance and support provided by the peers.

Patient-led discussion groups permit certain experiences to occur which otherwise would not be available to the patients. Some of these experiences are indicated here. Thus, patients have the preliminary opportunity to work through their distrust of people by confiding in their peers. Favorable experiences with their fellows permit the patient to bring up the same or deeper material for his staff therapist.

Patients in a group, like students, tend

to be more accepting and simultaneously more critical of each other. Thus, a given patient can be exposed to more severe criticism than staff could give, yet always in a context of sufficient support. The experience of being a leader of a discussion group permits the patient to see himself in a radically different light. This experience is perhaps best described in the adage "It is better to give than to receive." The advanced patient who has worked through some of his grosser problems in relating is in a position simultaneously to pass on his acquired wisdom (as a senior patient) and also to benefit from the experience of being a helper rather than a needer of help.

Finally, it should be noted that there are many therapeutic advantages to a patient placed in the role of leader. That such advantages obtain are apparent to trained leaders in terms of their own improved insights from conducting group psychotherapy. Furthermore, these advantages accrue to the patient leaders as a result of advantages that exist for the peer patients rather than (as is often supposed) at the expense of the peer patients.

Some criticisms have been made, and difficulties do occur. However, these criticisms were largely in terms of "what could happen." Typical objections were: the danger of exploitation of one patient by another, either deliberately or on the basis of unconscious needs; violation of confidences revealed, with overtones of blackmail; danger of psychological damage because of unskilled leaders, and the possibility of patients coaching each other with the "right" answers. In the experience of the writer, such pitfalls simply did not occur. The major difficulty the writer experienced was associated with the fears and resistances of colleagues. Some of the fears were based on the *a priori* expectations cited previously.

Favorable experiences were sufficient to resolve such apprehensions. On the other hand, some of the staff were genuinely resistive because of personal anxiety associated with perceived threats to their self-esteem as "trained group leaders."

A precursor to the use of patient leaders was the use of untrained employees as group leaders. The experiences with these leaders demonstrated the practicality of using untrained therapists (7). Thus, early results showed that the use of psychiatric attendants in a state hospital produced immediate improvements in communication with the backward or regressed psychotics. The clinical director was made aware of changes in mental status of these patients as soon as these changes became apparent to the leader. Secondly, the patients were given, and responded to, the additional staff attention, interest, and therapeutic optimism implied by the activity itself. Thirdly, the psychiatric attendants themselves began to change their outlook toward these disturbed people. Perhaps even more profound, the untrained leaders began to develop more self-acceptance and job satisfaction.

Another precursor to patient-led discussion groups is the experience of Bion and Rickman as reported by Bierer (3). Here, the staff leader's role was so passive as to be nonexistent; hence, a leaderless group. This technique has been described by Bach (2) under the rubric of "leadership by default." While not directly comparable to the present approach, both Bach and Bierer suggest that there are advantages to psychotherapy where the leader's overt participation is minimized and his authority delegated to the group at large.

In California, as elsewhere (4), increased therapeutic activities and responsibilities are being given to psychiatric technicians

(12, 13) in the Department of Mental Hygiene as well as to custodial and maintenance personnel in the Department of Corrections (5, 8). So far, the results seem to be in the direction outlined above. If these advantages can occur because of untrained personnel, it would seem reasonable to anticipate similar results with patients. This would seem even more likely with patients who are not psychotic and who are given an additional or supplementary method for resolving their interpersonal problems.

Since the concept of patient-led discussion groups implies the absence of observation by staff, supervision of patient leaders poses a difficult task. The inherent potential for good must be assumed from the outset or else the whole operation is impossible. However, granting that patients intend to help each other, in what manner can staff provide effective assistance and direction?

Three additional assumptions can be made that permit the staff consultant to draw conclusions concerning the nature of the patient leader's activities and subsequently to influence them. The first permits the staff consultant to infer the nature of a given patient's role as group leader. When the patient leaders meet with the staff consultant in an unstructured group therapy-like meeting, the patients tend to perceive the staff leader in terms of their own preconceptions of good and bad leadership. The consultant can observe directly the nature of a given patient's perceptions, motivations, and expectations toward the staff leader. In short, the patient leader will relate to the staff leader in terms of the structure imposed on the peer patient group: e.g., if the patient leader perceives the staff leader as snobbish about education, one can expect to find the same patient reacting to his own peers snobbishly with respect to education. Another example

would be the patient leader's misperception of the staff leader as knowing all the answers. This same patient would tend to impose a know-it-all role in his patient-led group discussion.

The second assumption concerns the staff member's effort to facilitate better group leadership by the patients. Patient leaders, and staff leaders too, tend to structure their groups according to their own needs, values, and preconceptions. Such an alteration of a need, value, or preconception subsequently alters the nature of the group structure. Since his primary responsibility is to improve group leadership, the staff consultant does not attempt a broad effort at psychotherapy. Instead, he addresses himself to the specific needs, values, and preconceptions that interfere with good group leadership. Thus, the staff leader conducts group psychotherapy with highly selected goals for the patient leaders. The goals in this situation are the modification of those factors that determine a patient leader's notion of "good" leadership. Where his preconception of the good leader is recognized as detrimental to effective group processes, the staff consultant should attempt to work through the source of the patient's attitudes. The sources are visible during the course of the meeting with the consultant, albeit in terms of the inverted leader-peer relationships.

The third assumption concerns a more indirect method of influencing the patient leaders. The staff consultant, by his behavior, provides a model of the good leader for the patient leaders. His example, manner, and attitudes become ego ideas which the patients tend to introject in their efforts to lead patient discussion groups adequately.

In his efforts as staff consultant, the writer attempted to conduct his group of patient leaders in the following manner:

First, an attempt was made to provide an atmosphere of acceptance and safety for the patient leaders in the group led by the staff consultant. This effort was achieved by permitting attendance and participation to occur on a voluntary basis. In addition, patients were allowed to move at their own rates with respect to such issues as being evasive or noncommittal at any given moment, attacking or criticizing the staff leader, or persisting in some autistically derived perception even when the group consensus specifically contradicted it. A potent device for conveying an accepting attitude was the specific intervention on behalf of a given patient at times of pressure or distress. Such intervention was intended and perceived as giving relief to the patient in his hour of most acute need, even though this, in effect, prevented the group from achieving its objective.

The staff consultant indicates by his behavior that any subject matter is legitimate, regardless of how trivial or irrelevant it may appear to be. However, by periodically asking the group, "Why are we discussing this topic?" the staff leader brings attention to the underlying motivation. It soon becomes apparent, in terms of patient needs, whether or not a given content is relevant for discussion.

In addition to the foregoing, the role of the group leader, as demonstrated by the staff consultant, stressed efforts at focusing attention on the irrational behavior of any one member who was voluntarily presenting an issue to the group. The group's attention was directed, by means of the leader's verbal invitations, to describe, react, or otherwise comment on the behavior of the patient discussing his problem. Specific interpretations are left to the members of the group. By this example, the consultant conveys a preference for group judgments rather than leader interpretations.

Thus, the likelihood of promiscuous or arbitrary intellectual interpretations by the patient leaders is diminished, if not entirely eliminated.

The use of patient leaders for discussion groups represents an evolution in the concept of the treatment milieu for mentally disturbed patients. This approach mobilizes patient energy, interest, and good will for the purpose of mutual aid. In the process, a more effective working through of morbid feelings occurs. In view of the typical limitations on available staff effort, such extensive working through can be presumed not to occur, or to occur insufficiently, unless alternative measures such as the foregoing are provided. However, the most profound aspect of the patient leader program is the alteration in the self-image of the patients selected as leaders. To be perceived as a giver of help rather than as a needer of help is a self-enhancing process. It tends to dissolve the arbitrary stigma of abnormality and facilitates greater self-acceptance. Such a program supplements the hospital-wide effort at rehabilitation by preparing the individual for a contributing role in society, which, ultimately, is the major goal of all mental hospitals.

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Casework interviewing as a research technique in a study of families of schizophrenic patients

INTRODUCTION

When a technique such as that of casework interviewing is used in an intensive family study, it quickly becomes apparent that it is the interviewer who is the tool and the method. It seems useful, therefore, to consider the technique as applied and experienced by a caseworker in a special project. This is a study of the families of a small number of young schizophrenic patients. We have been particularly concerned with the interaction among family members, the many kinds of equilibria which become established with varying degrees of success and stability, and the forces which act upon these equilibria, tending to preserve or disrupt them. Feelings and attitudes which may never be put into words, discrepancies between what is said and what is done or implied, must be noted along with apparently more easily interpreted historical "facts."

Quantities of material may become

readily available, but major problems lie in the selection, evaluation, and interpretation of the data, and these processes are inextricably involved in the gathering of information. Casework interviewing provides a technique which is adaptable in many ways and which can be sensitive to subtleties and intricacies, changing to suit particular conditions or to take advantage of unexpected opportunities. Inherent in the technique and inseparable from these assets are certain liabilities. A very personal skill, it must be dependent upon the individual using it, his sensitivity, flexibility, and prejudice. Its very adaptability

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makes difficult the comparison of findings from one case to another and the standardization of results.

In the part of the project to be discussed here, we have been studying 16 cases, working intensively with the patients' relatives for at least eight to nine months and sometimes for three or four years, depending on the length of the patient's stay in the hospital. The patients have been selected from among those hospitalized in the Yale Psychiatric Institute, a 44-bed nonprofit private hospital which serves also as a training and research center (4). Aside from diagnosis, the major criteria determining choice of patients were the availability for interviewing of the mother and at least one sibling and the relative youth of the patient. In all families except one, the fathers have been available and have been seen for a number of interviews. Since this is a private hospital, the families are generally well-to-do. Our sample is therefore biased in favor of unbroken homes, in which the wage earner has been either functioning well at his job or under no pressure to produce income.

Our major concern is with the interplay of personalities in the family group. Therefore, we do not consider the mother-child relationship a closed system. We are interested in observing ways in which each member of the family affects and is affected by the patient both directly through personal interaction and indirectly through relationships with other members of the family. Social and cultural pressures which might produce stresses within the family must also be noted.

Patterns of identification are of particular interest. A successful masculine identification may be difficult for a boy to achieve when his father's bizarre manner is represented as ordinary male behavior. It may also be affected by a mother's belittling or

contemptuous attitude toward her husband, the father's competitive attitude toward his son, or either parent's seductive behavior toward him, as well as combinations of these factors. Further complications are added by the presence of siblings, rivalries among them, their tendencies to form alliances with one parent or the other, etc. We may be interested in learning why one child "chose" to identify with healthy aspects of the parents and another with their more disturbed behavior.

Difficulties in perception and communication, too, are matters for concern. Has the child learned distortions in certain areas by identification with disturbed members of the family? Are these distortions perhaps related to a subtle glossing over of the unpleasant realities, actions contradictory to the apparent meaning of spoken words, or are they derived from the direct teaching of paranoid or illogical ways of thinking? Has the development of such patterns come about as a defense against an accusation, actual or implied, or some other kind of pressure?

We cannot hope to trace all the intricacies of these many networks of action and reaction, but we can keep them in mind and try to follow whatever leads we find in our hands.

An opportunity for observation of these phenomena is provided in the long-term casework treatment of problems brought to us by these families. There is sufficient motivation for both family and interviewer to engage in extensive exploration of troublesome areas. A gradual unfolding takes place in which, it is to be hoped, both the relative and interviewer can see the situation with increasing clarity. We recognize that in entering the situation at all, we are changing it. Doing this by means of a planned therapeutic approach gives an opportunity to test hypotheses, explore other-

wise inaccessible areas, and observe new phases of interaction.

SOME PRACTICAL ASPECTS OF APPLICATION OF THE METHOD IN THIS SETTING

Since, for many years, casework with the patients' families has been an integral part of the treatment program in this hospital, it has not been necessary for the research worker to depart very far from routine procedures. For purposes of the study, a more determined effort may be made to have all family members keep regular weekly appointments even when it seems unlikely that they will make constructive use of the service. Some information not immediately applicable to the therapeutic approach may be sought, but in general, these cases are handled more intensively rather than differently from others.

The social worker's contact with the relatives begins as soon as the patient is admitted to the hospital, sometimes even before his admission. Several reasons may be given for the appointments with the caseworker, and the order and emphasis with which these are presented may be varied, according to the individuals. Relatives are encouraged to use the caseworker as their liaison with the hospital, discussing with her their questions regarding hospital procedure and regulations; what they may or may not bring to the patient and why; what changes might take place in his behavior toward them, etc. They are told that we believe we can understand the patient better and work with him more effectively when we know his family and can learn about him from them. We tell them, also, that, because we realize that the hospitalization of a family member is upsetting, we believe the relatives should have available to them for regular appointments a social

worker, a specialist in family problems. Group interviews such as those employed by Ackerman (2) and Bowen (4) have recently been initiated with some families. In all cases, parents have met a few times with one of the psychiatrists, generally for discussion of particular questions related to planning for the patient. With some individuals, the interviewing has been done by one of the psychiatrists on the research team. This arrangement was made in some cases because a parent seemed unusually disturbed and in others, because it seemed desirable to have husband and wife see different interviewers. Possibly because these have happened also to be the senior staff psychiatrists of the hospital, one result of such an arrangement has sometimes been that other family members lose interest in seeing the social worker.

Most of the relatives assume that in a university hospital, our data will also be used for study purposes, but this is not discussed specifically with them unless they bring it up. Usually, it does not occur to them during their initial anxiety over the patient's hospitalization. After the relationship is established, the idea of research is accepted, if it arises at all, with little evidence of concern.

The initial reactions to appointments with the social worker vary. A few may want her to run errands or listen to complaints about the hospital and see that things are changed. Some want to see only the administrative head of the hospital and are indignant at having to settle for less. Nearly all are very anxious and defensive, and those who are aware of it are grateful for the special attention and the opportunity to unburden themselves. Whatever the initial reaction, most accept the contact readily enough to permit establishment of a workable relationship.

A number of different and sometimes

changing motives serve to keep the relatives in contact with the social worker. Most hope to learn about their patient, his life in the hospital, and his progress. Plans for the patient's employment, tutoring, school, and, eventually, discharge arrangements may need to be discussed. Parents, and often siblings, feel intensely guilty, and this can lead them to wish to prove their willingness to help. A few relatives would like to escape from the situation. Many are frightened about themselves and seek reassurance that they are not sick, too. Some feel the need for help in learning to cope with family problems bearing on the patient's illness.

As many sources of data and opportunities for observation as possible are explored and developed. Regular attendance at staff conferences and frequent discussion with the patient's therapist are essential, of course. In addition, the caseworker spends time on the ward, making the acquaintance of the patient and gathering impressions of patient and family visitors from nurses and ward aides. Home visits yield particularly valuable data, and the social worker is sometimes able to participate in family parties, birthday celebrations, etc. Whenever possible, school teachers, old family friends, nursemaids, etc., are interviewed.

Notes are dictated, usually on the day of the interview, from memory alone. This is a personal preference. Recorded interviews would give accuracy of a sort but would produce masses of unwieldy material. A few recorded interviews with each individual could be valuable, but we have not used them as yet.

All family members are asked to take psychological tests, and these are studied to determine what can be learned from them of family relationships, patterns of identification, etc.

Case material has been discussed regularly at weekly meetings of the research team.

SPECIAL USEFULNESS OF COMBINED CASEWORK SERVICE AND RESEARCH

The patient's stay in the hospital, as well as the project's study of the family, may depend upon successful work with the relatives from the start. Many parents are not sure they have made the correct decision in hospitalizing their son or daughter, and the patient, ambivalent toward both family and hospital, will often make destructive use of the family guilt and fear. Immediate evaluation of the parents' anxieties and efforts to meet some of their needs may reduce considerably the danger of discharge against advice.

A history obtained over a period of time from several informants in free and spontaneous discussion is particularly rich in color and depth. Accounts of the same incident by various family members may be pieced together to give a rounded picture. It is often possible to evaluate contradictions and to make a fair guess at the degree of distortion in the material provided by each informant.

Mrs. L. described a visit to her daughter, in which, she said, the girl had flown into an entirely unprovoked rage at her father. Mr. L., in his interview, reported that, in spite of the patient's obviously irritable and upset mood, he had involved her in a complicated legalistic argument in which he exposed and ridiculed irrationalities in her thinking, and it was then that she had attacked him. When this is brought together with other similar incidents, we can see the mother's protective and subtly belittling attitude toward her husband, Mr. L.'s provocative behavior toward his daughter, and Mrs. L.'s denial of it.

Long contact makes possible observations of the family through major and minor crises and also induces spontaneous revelations of a more intimate nature than are obtained in a few interviews.

Mrs. L. did not confide for almost a year that her husband had suffered a mental breakdown several years before, and, since he had never fully recovered from it, the major responsibility for running the family business fell upon her while he kept up appearances but remained inactive and only a figurehead. This gave us both important historical material and a sample of behavior to compare with that in the relatively trivial incident described above.

Changes in the family which appear to result from our therapeutic intervention may shed light on some of our hypotheses. We noted that one mother of a sixteen-year-old schizophrenic son clung very tightly to her children, particularly the boys. It appeared that this might be at least partially explained by her difficult marital situation and consequent need to obtain affection and gratification elsewhere. We found evidence to support this when, after the stress in the marriage was eased, partly through our efforts and partly through external events, she became less indulgent with the patient's younger brother and set more reasonable limits when responding to his demands.

Much can be deduced about the family from the relatives' behavior toward the interviewer. An apparently routine event or casual conversation may be far more revealing than the replies to direct questions.

When Mr. S., the father of a schizophrenic adolescent girl, wanted to entertain the social worker accompanying his daughter on her first visit home by telling sexual jokes, the worker's dilemma in handling the situation revealed much about the pressures the patient has experienced in her life in this family. Laughing at the jokes would offend the mother and the patient, who were maintaining a stony silence; not laughing would inflict a painful wound in

the father's very tender narcissism. Considering this, together with the patient's propensity for playing off hospital versus family and staff-member against staff-member, we can see the total situation with greater clarity. This was further illuminated in a quarrel between the parents, which took place in the interviewing room. They had been informed that their next week's appointment would be canceled because the social worker would be out of town. They assumed that it was to be a vacation, and Mr. S. insisted Florida was the place. His wife said Florida was a dreadful spot. Suggestively, he remarked that he was going there soon for professional meetings. She glowered. Suddenly, he proposed the city where they lived, and both were in immediate, if brief, agreement. The worker could stay in their apartment and sleep in their daughter's bed. He said she could go to the theatre every night. She said grimly that he never takes *her* to the theatre, and so it went, giving a clear picture of a scene which must have been re-enacted many times over in their home with their daughter.

In the same way, childlike dependency, hostile condescension, supplicating, friendly, aggressive, or ingratiating behavior toward the social worker all demonstrate much of the family patterns of interaction. While complaints are an interesting area for studying some situations, the absence of justifiable complaints is equally revealing. In these situations, the "feel" of the interaction is at least as important as what is discussed directly.

SOME PROBLEMS IN THE APPLICATION OF THIS METHOD

A few special problems arise in this application of the casework technique.

There are times in the combined approach of service and research when one must be adapted to give way to the other.

In occasional instances, the two may be in direct conflict, but these have been relatively rare. Often the two are closer together than is immediately apparent.

An invitation from the B. family to go with them to the ward for a celebration of the patient's birthday was accepted eagerly for research purposes, but reluctantly, because their son, who was depressed at the thought of a second birthday in the hospital, might be even more disturbed by the presence of a guest invited by his family. He was upset, but the party itself provided valuable material for discussion with the parents regarding their difficulty in recognizing his rude and ill-mannered behavior. A week or so later, the patient spontaneously asked to talk over the incident with the social worker. He apologized, acknowledged his need for control, and indicated anxiety at being offered his family's explanation that he "was not feeling well." It was, therefore, unexpectedly useful from a therapeutic point of view.

Pressing an anxious informant too far might arouse resistances which would defeat research as well as therapeutic goals. In one or two cases, we became concerned for fear we might be upsetting the families too much. Their anxiety subsided, however, and it seemed that it represented a necessary phase.

In order to have a degree of uniformity of data, it was decided that one interviewer should, whenever possible, see all family members. Problems of transference and counter transference have, therefore, been very complex. The social worker does not relate in the same way to all people interviewed. She has likes and dislikes and personality traits of her own which make for more productive relationships with some individuals and less productive contacts with others.

Some families are very free and probably

fairly reliable when giving historical data. In a few cases, there is only a very scattered and "unreliable" family history. Always, we have our own observations of current behavior in a stress situation, which is fairly constant from one case to the next, although, even in this, there are variations if there have been previous hospitalizations.

When there have been sharply divided allegiances within a family, it has sometimes been hard to avoid taking sides. Furthermore, even a mild demonstration of interest in the marital partner's history can aggravate the conflict and reinforce resistances with results which might interfere with the achievement of either therapeutic or research goals. A mother who was inclined to project all her problems on her disturbed and very difficult husband brought up dramatic historical information concerning him, of a sort which he would be likely to conceal just at the time when it seemed wise to try to help her check these projections and encourage her to think more about herself and her own part in the family difficulties. Interest shown in this material at this time would probably tend to reinforce her projections and to close off useful data concerning herself, but the information was valuable; it would probably not come up again nor be available through other family members. Bringing it up later would only give it more emphasis. It was discussed but in less detail than might have been desirable from the point of view of our research interest in the husband's psychopathology.

Relationships of the social worker with other members of the staff, both research team and other hospital personnel, have a marked effect on the data. Suggestions may be made concerning new lines of thought or other ways of working with the case. This can be both stimulating and reassuring. It introduces some checks on

the subjectivity of her impressions but adds, of course, other subjective impressions. At times, the combined hostility of the group toward a particularly trying parent has complicated the worker's efforts to handle her own hostility. In other instances, she has felt pressed to protect a relative from attack by the group or by the patient-therapist combination. No doubt these circumstances affect both the data and the relationships concerned. Mutual confidence and understanding between therapist and caseworker can facilitate the free exchange of ideas. The occasional lack of it limits understanding of the case and affects the worker's relationships with family members.

The fact that the relatives are not told of the research probably complicates the social worker's feeling about her work with them. The decision to omit discussion of the use of data for research purposes was based on a pilot study made of four families by Dr. Beulah Parker. Two who were told of the research became unco-operative and suspicious, fearing that they and their patient were being exploited, even though they were, in fact, receiving extra care and attention in addition to the reduced rate then available. The other two families, who were not informed of the research, were much more inclined to participate in a helpful way. At that stage in the research planning, efforts were made to avoid therapeutic intervention with the families, but these were not very successful. It seems possible that this, together with the fact that the families were singled out in seeing a psychiatrist rather than a social worker, might have affected the findings, but we have not tested it.

A related problem, still unresolved, is that of confidentiality. In a comprehensive study such as this, it is difficult to work out satisfactory disguises. Even if we could make the families unrecognizable to their

friends, it would be next to impossible to disguise them from themselves. A father who has confided in us his extramarital affairs would not like to have his wife read their case history. It might be a shocking discovery for a mother to learn that we believe she needs her child's illness in order to give her life a focus and direction, or for a father to read that his son considers him strongly homosexual. Since our families are relatively sophisticated, we cannot be sure that they will never pick up a book or article signed by people they know, coming from the hospital where they have had a patient. This thought poses a serious problem for the caseworker who is seeing the families. At times it is possible to repress it, but there is no doubt that it is always present, and that it does interfere.

Occasionally, the caseworker experiences a kind of pressure from the fact that she needs something from these relatives even when they do not feel the need of anything from her. Parents in one family were exceptionally anxious at the thought of the interviews and found innumerable reasons for not making or keeping appointments. They insisted upon evening appointments which they canceled minutes before the hour "because they were tired" or kept the appointment and then let it be known that they could as easily have come during the day. Had they chosen to come because of their own need, this might have been interpreted as provocative behavior, hostility, resistance, etc. Here, however, we needed them more than they thought they needed us, and the worker's resentment could not be so easily dissipated.

Data obtained by casework interviewing is open to challenge on the basis of the subjectivity of the approach. It is true that even in the broadest aspects of the consideration of such material as this study provides, the part played by personal biases

is great. It is possible in extensive and detailed case histories to find or to project evidence in support of almost any hypothesis. Collection of data cannot be separated from interpretation, and the impressions of the interviewer are, of course, subjective ones.

Personal biases of other members of the research team and the various personalities play upon and interact with the various aspects of the interviewer's personality, checking the subjectivity of her observations in some ways, complicating it still further in others. In another similar project, an analyst, having no investment in the outcome of the study, was found to be very helpful in conferences with those collecting the data, but this, of course, adds another subjective impression, and this could go on ad infinitum (3).

We are dealing here with changing quantities, shifting equilibria, subtleties which are observable at some times and not at others, and intensities which can be compared roughly, but only roughly. Only a sensitive and adaptable method could provide the material necessary to such a study. The same factors which we hope may contribute these qualities will also produce unevenness and distortion in the data. Paradoxically, when such "errors" are discoverable, they can further our understanding of the families. The value in the procedure lies in the color and depth and intimacy, the richness of detail, in the picture of life in these families as we see it unfold before us.

SUMMARY

In this study of families of schizophrenic patients, much of the material has been collected through casework treatment of family problems similar to that offered all families of patients hospitalized at the Yale Psychiatric Institute.

This method makes possible the study of interacting personalities within a family group as the several members bring up for discussion their problems in relationships. Observations can be made as relatives interact with each other and with the hospital staff through times of crisis and periods of increasing or diminishing tension. Changes which appear to occur in response to therapeutic maneuvers may tend to confirm or contradict hypotheses. Several accounts of the same event add detail and give cues to distortions and differences in perspective.

The subjectivity of the method gives rise to unevenness and inaccuracies. The same factors which introduce these defects, however, make possible the major contribution of such a method and the perception of subtleties and details in the interlocking human relationships in a family.

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Some observations on the therapeutic process in child psychotherapy

There is a story that an American university set up a committee to report on the requirements for training of psychotherapists. The committee first attempted to offer a definition of psychotherapy and arrived at the following conclusion:

"Psychotherapy is an undefined technique for unspecified conditions with unpredictable results." They added: "This technique requires a thorough training!"

In England, Ernest Jones stated succinctly that there are two kinds of psychotherapy—psychoanalysis and suggestion. Suggestion is a word of bad repute, and, therefore, we presumably are left with only psychoanalysis; and it is true that it is to psychoanalytical studies that we owe any understanding that

we may have of psychotherapeutic processes.

Suggestion is the name given to the process whereby an individual is influenced in his thoughts, feelings, behavior, or symptoms by another individual without—or with minimal—conscious participation.

Psychoanalysis, or therapy based on psychoanalytical studies, is distinguished by the development of insight into the unconscious processes that accompany, or are responsible for, our illnesses, and, in order to achieve this, it is usually necessary for the therapist to use the tool of interpretation. Insight, however, is not enough. The therapist aims at giving first understanding of, and then responsibility for, the symptoms to the patient. The patient's consciousness is enlarged and so is his responsibility and even, in some senses, his burden. In Freud's words: "Where Id was, Ego shall be."

Psychotherapy has existed throughout the ages, and although in recent centuries it be-

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came separated from the treatment of physical disease, the prophet of Biblical days was both physician and spiritual healer.

Freud's work was, thus, not the first in this field, but it was the dividing line marking the period after which the processes involved became themselves the subject of scientific study. It was a practice before it became a theory. Freud himself first developed a technique and later began to study what it was that he was doing. He studied the symptoms of his patients and made deductions about the relationships of these symptoms with events in their lives. He found that his inquiries into these relationships influenced the course of the illnesses and seemed to be responsible for cures; and he then began to study the process of the cure. After he had applied the word "psychoanalysis" to the process, he continued to analyse not only what occurred in the patient but also the process of the analysis itself. He extended this study into his own participation in the process.

Psychoanalysis shares with the physical sciences a foundation on an act of faith. All science is based upon an unprovable assumption: namely, that the universe is understandable. Without that assumption, we would not look for the regularities in nature that we call "physical laws." In studies of meanings in chemical and physical structure, the meanings are expressed sometimes in the form of measurements. In other instances, including many of the studies of mental life, the meanings are expressed in terms of sequences and relationships. The special assumption that forms the basis of psychoanalysis is that our thoughts, feelings, behaviour, and our illnesses also have meaning, or make sense, and that our symptoms and our apparently irrational behaviour may serve a useful purpose in our lives.

Nigel Walker, in the *Short History of Psychotherapy*, published by Routledge and

Kegan Paul in 1957, draws a distinction between descriptive statements and explanatory statements. Explanatory statements take the form of models. Freud first made observations and then began to search for explanations of his findings in terms of mental structure. In this way, he was led to provide theories of the structure of mind, and these theories became the basis of further observations.

Freud's early models were derived mostly from the physical sciences. Lord Moynihan used to describe himself as a physician doomed to the practice of surgery. It could be said of Freud that he was a neurologist doomed to the practice of psychoanalysis. His glimpses of understanding are revealed as they developed, in *statu nascendi*, in his correspondence with Fleiss, and one can follow the way in which he was forced, almost against his will, into the formulations of new concepts of mental life. His observations on psychosexual development were carried out fearlessly in spite of loss of popularity with colleagues.

His techniques of treatment were based upon a pact with each patient whereby the patient agreed to put at the therapist's disposal every thought that his self-perception could provide, and the therapist offered in return his understanding of that material, together with an interpretation of some of its unconscious meanings and connections.

The theory of mind that was at the same time evolved was expressed in four different types of model:

1. *Topographically*, in terms of Ego, Id, and Superego;
2. *Dynamically*, in terms of mental forces such as repression, projection, and resistances;
3. *Economically*, in terms of distribution and redistribution of libido, explaining symptoms as the accumulation of tension, and relief as its release; and

4. *Historically*, in terms of the development of the individual with stages of oral, anal, and genital dominance in infancy, and the passage through nuclear situations, such as the Oedipal stage.

He enriched the description of mental life with a new vocabulary that has passed into common speech, sometimes inaccurately used.

The process of psychoanalysis came to be applied to particular disturbances. Hysteria, anxiety states, obsessional and phobic states received the most attention. Psychoses were not exempt from study, and not only the depressive states, but also the delusions present in schizophrenia, were shown to be comprehensible, even if the course could not, at that stage, be influenced.

Disturbances in childhood were, for a while, considered to be outside the range of psychoanalysis. The story of Little Hans in 1919 gave an account of an attempt to understand and to treat an obsessional neurosis in a boy of five years indirectly through interviews with the boy's father. Hug Helmut began to treat children over the age of six years. Melanie Klein, in 1919, was the first to apply analytical methods to small children by means of an addition to techniques. She allowed the child the use of small toys and treated the play with the toys as the material through which the child communicated. Melanie Klein developed new views about the early formation of processes in mental life. Her "model" of mental development is in the form of the incorporation or introjection into the personality of the child of "objects" which are mental representations of his parents or parts of his parents. Both Freud and Karl Abraham had previously used the idea of object relationship in this sense, but Melanie Klein made this process the foundation of her theories of mind and the basis of her technique in treatment. Some of her fol-

lows speak of "good objects" and "bad objects" and of "internal objects" and "external objects" in phraseology that almost implies that these objects have material existence.

I should like to mention here the existence of schools of psychotherapy formed by former associates, followers, or opponents of Freud. Different models are built up and are spoken of as if they represent an actual material structure of mind or of personality. When we study mind with the instrument of mind, the nearest that we can get to it is an analogy. We can say of all these theories or analogies, as did Theseus of the play within the play in *A Midsummer Night's Dream*: "The best in this kind are but shadows and the worst are no worse if imagination amend them."

Of some of these theories, we can add, as did Hippolyta, "It must be your imagination then, and not theirs."

And of the anthropomorphism of many explanations, we can say, from the same play, that "As imagination bodies forth the forms of things unknown . . .," the psychiatrist's pen, as did the poet's, ". . . turns then to shapes and gives to airy nothing a local habitation and a name."

It seems also that some exponents of individual schools advertise their uniqueness as do the advertisers of detergents on TV rather than attempt to discover what resemblance they may have to other products in the same field.

Modern child psychiatry is founded largely on the work of Melanie Klein and Anna Freud. Anna Freud differs from Melanie Klein in her view of the transference situations, but she, too, uses imaginative play in treatment.

Psychiatric treatment of children is, at present, carried out largely in child guidance clinics, the first of which to be founded in England was under a voluntary body

in 1927. They exist now under local education authorities, local health authorities, regional hospital boards and hospital units, and teaching hospitals. The words, "child analysis," "psychotherapy," and "play therapy" have been used to describe techniques that are widely divergent and are used loosely, as if synonymous with the words "child guidance."

Here, too, techniques first were developed, and, from observations on the application of the techniques, theories have been built up regarding the development of personality, and concepts of illness have been formulated. The aim of most techniques is to develop a medium of communication. Some therapists use a special setting or framework within which to work. The methods and materials employed include: play with toys, drawing, painting, plastic materials, puppets, extempore drama and music, and specific materials out of which a child may construct a world of his own. These are used to help the child to project his ideas and to allow the therapist to put them into words for him. Some therapists become skilled in the use of particular media, but too-complicated a setting can become a barrier rather than a communication between child and therapist.

Other methods of treatment include drugs, physical methods, and hypnotism, and there is also the practice of influencing the child by more indirect means: e.g.,

1. *Through the parent*, by direct treatment of the parent or by helping the parent to develop new ways with the child;

2. *Through the more general environment*,

- (a) by removal of pressures on the child;
- (b) by providing material help—food, clothes, or equipment;
- (c) by removal of child from home

or school, providing a new environment;

- (d) by increased recreational facilities; and
- (e) by encouragement of special abilities.

It is the practice to accompany treatment of the child, in nearly all cases, by interviews with the parents in order to obtain a history of the disturbance, to interpret the disturbances in the child's mental life to the parent, and to prepare the parents for the adjustments that will become necessary as the child makes progress.

Treatment of the child alone, except when adolescence is reached, is usually inadequate and often unjustifiable. It is inadequate because no child lives in isolation, and he can be understood only in relation to family life. Moreover, a symptom in a child may be the presenting symptom of a disturbance which extends through the whole family, but in which only one individual seems to be carrying the burden. It is unjustifiable because one should not expect a parent to allow changes—even beneficial changes—in his child in which he himself plays no part, and which he may not understand or approve.

Some parents, however, demand that treatment should be confined to the child, with the *proviso* that the child should be changed by the therapist into a pattern which the parent has considered normal but which he himself has failed to impose.

One must beware of too-facile and too-simple explanations of a disturbance in giving interviews with parents. A parent is ready to quote the psychiatrist as having attributed the entire disturbance to a single and sometimes improbable cause. One is often accused of attributing a behaviour disorder to "too much discipline," and the suggestion is then made that psychiatrists

recommend the absence of discipline. I have also heard of a mother who said that she had gathered that what she had done wrong was to have her first child first.

Parents are sometimes resentful regarding the use of play as treatment. Play is an indulgence, and it seems wrong to them that it should be permitted in the case of a child who has been brought to the psychiatrist after all other threats have failed.

I should like to discuss the actual process of treatment under five headings: relationship, communication, interpretation, insight, and utilisation of the insight within the patient's life.

Relationship in the case of a child is twofold. First, it may be a transference relationship, in which the therapist appears in the child's fantasy as a representation of aspects of the child's parents. Secondly, the therapist acts in his own right and sometimes serves as a model from which the child may, for the first time, introject qualities into his personality.

These two aspects correspond somewhat to what Slavson describes as "libidinal transference" and "identification transference."¹

All the other processes take place against the background of this relationship, and the relationship is reciprocal—transference and counter-transference. The rapidity of the building-up of a transference relationship justifies the belief that counter-transference comes first. A therapeutic relationship can only be built up between child and therapist if the therapist can first give respect to the child as he is, without attempting to manipulate him, giving him freedom to talk or play or to be silent and inactive, with the *proviso* only that the silences or inactivity may be interpreted.

The patient's feelings are described as positive or negative, but they may be both at the same time. The attribution by the patient of qualities beyond those which the therapist actually possesses may please the therapist, but they are a demand upon him to fulfill that fantasy or face the consequences.

As an example I would like to quote from a letter received from an adult patient:

"In my world of fantasy, you have been all things to me—mother, father, friend, teacher, guide, and many other things, according to my mood and needs of the moment. For me you have possessed the gentleness of a woman, the logic of a man, the understanding of a teacher, and the wisdom of a guide who has trodden the same path many times and appreciates all the dangers without trying to dodge any of them. I have complete confidence in your ability to allow me to do and say only those things which will not violate my code of behaviour. But I am always desperately afraid that in one of my moments of dependence I might say or do something which is completely out of character. I have a strange Puritanical streak in me, and in my fantasies have many thoughts for which I despise myself, and I am always afraid they might pop out into the conversation. I still cannot accept your maxim that it is right to give voice to all one's thoughts. . . . I cannot just let off steam and rant and rave at you, however much I feel like it. I just get quiet and shut up within myself at the times when I most need to let myself go. I am sane enough to know what is fantasy and what is reality but not sane enough yet to put aside that fantasy and live in a real world."

This is from a patient whom I have seen approximately once weekly for about two years, and a large part of each session is spent in silence. I might add that in the

¹ Slavson, Samuel R., *Child Psychotherapy* (New York: Columbia University Press, 1952).

beginning of this letter, there is an implied reproof for my absence on holiday during the previous three weeks.

Children are more ingenuous; they make direct attacks with words or play materials, or they sometimes use their drawings to express the situation symbolically.

Communication is possible only when there is an understanding of the material presented. At the first interview, it is a practice to invite the child to draw.

With every drawing, I ask myself, but not the child, the following questions:

1. What is it; what is the content of the drawing?

2. What are the sources of the material—whether primarily done at school, derived from story books or observation—or if it is mainly from the child's own inner mental processes?

3. What are the meanings which can be attached to the drawing? The child's own thoughts in association to the drawing might help; the therapist's associations may be of equal value, and these may or may not be disclosed at the time. To show that the attachment of meanings to drawings is not confined to child psychiatry, there is the painting by Sir Winston Churchill. The painting is of a small tree which is enclosed by two larger trees leaning towards each other, and the title is "Custody of the Child."

4. What was the purpose of the drawing? Why did the child select that subject and at that time?

5. How can we use that drawing in communication or treatment?

Play may also be a means of communication in the same way, and both drawing and play with toys may be a joint activity of child and therapist and, thus, have a value beyond that of communication in the development of the relationship between the two.

Interpretation is chiefly a verbal process. The therapist finds the words for the ideas that the child is trying to express in other ways. Interpretation may aim at undoing repressions, disturbances, and displacements responsible for psychoneuroses in children, or the aim may be less specific. A question asked by the therapist or even his silent acceptance of the child's products may be interpretive. The child interprets the therapist's activities, just as the therapist interprets the child's. This can be illustrated by the story of an anthropologist who became the fortunate witness of a ritual dance of a little known African tribe. The dance was accompanied by a chant in a language that was unfamiliar to him. He therefore attempted to record it in phonetics and succeeded in making a note of a phrase which was repeated interminably. When transcribed, it read: "The white man is writing it down!" We should remember that, while we are participating observers, the child is an observing participant.

It is interpretive to complete what the parent or child has only partly said. An example of this is of a mother, with arms akimbo, who, when invited to "tell me something about the problem," replied: "I have told this story a half-dozen times already" and continued then with a defiant silence. I continued her sentence—in the same melody "... and not got much help." This immediately produced her story. My interpretation of her remark was accompanied by her interpretation of my completion of it. It was as if I were promising that here she would get help. That is the danger of permission to communicate and interpretation of the communication. It is a promise to help that must be kept, and it should be not lightly made.

Insight is not merely the release of unconscious material. A psychosis could do that for us—there is plenty of unconscious

material to be had in the verbal and artistic output of a psychotic patient. There are young children, too, who seem to have their "unconscious" on the surface.

Insight is the perception of unconscious motives and mechanism in relation to conscious behaviour. Partial familiarity with psychoanalytical concepts has led psychotherapists to welcome, from patients, material which seems to come straight out of the early psychoanalytical writings. When it is produced as easily as that, it serves no purpose in treatment.

Many child psychiatrists are becoming aware of greater numbers of psychotic children being referred to them or being recognised by them. The methods of treatment which have become almost a routine in child guidance clinics are inadequate for these patients. Some of these patients seem to improve with modifications of the routine. Attempts at interpretation are omitted. Conditions within the play room are maintained as constant as possible. The therapist and the therapist's room become the one fixed and unchanging factor in the child's life.

When drawings or play are not interpreted verbally, therapy may occur at another level. Each of these activities has satisfaction in its own right. These activities can be recapitulatory, reparative, or integrative. They can be recapitulations of problems in a way that helps the child to absorb his anxiety by familiarity, and reparative if leading to a different conclusion from the unsatisfactory sequences in past experience. The activity can also be integrative; the expression or externalisation of unconscious material can allow it to be

reabsorbed more safely. Perhaps modern art serves this function for the artist and also for those who find pleasure in viewing or owning these works. Some of the "action" paintings seem to resemble fecal or seminal discharges. The finding of beauty or of value in these products has widened the boundaries of normality. The finding of some kind of pattern in the apparent chaos builds up again something new after the destruction of the traditional limits of artistic expression. In the case of the child patient, he needs the therapist's acceptance of these productions to give the feeling that he himself has value, and that his efforts are neither worthless nor dangerous.

Some children with borderline psychotic illnesses may show uncontrolled behaviour in the playroom, which builds up to a crisis which seems to have orgiastic features. When this has led to his rearrangement of the furniture of the room, and it has remained for him next time, or when his chaotic drawings have been preserved, something seems to be added to the child.

Rapid cultural changes may be an important factor in the failure of some children to develop stable personalities. Margaret Mead referred, in a lecture to the British Psycho-Analytical Society,² to the constantly changing shapes and textures of the articles in common use in the home and in the general surroundings of adult life. Moreover, the various shapes of utensils, furniture, and houses have not only parted from tradition, but they also seem unrelated to each other. In primitive society, the shapes are constant, and even if parents' moods alter, the roof under which they live retains its quality of safety and kindness.

The therapist's room and his dependable presence at the time of the regular appointment are important factors in the therapeutic process.

Perhaps the giving of this dependability

² Mead, Margaret, "Changing Patterns of Parent-Child Relations in an Urban Culture," *International Journal of Psychoanalysis*, 38 (November-December 1957), Part 6, 369-78.

to the individual who needed to be dependent and who was afraid to trust anyone is the way in which we contribute to the process that has been called "ego strengthening," and it is a form of growing up.

Utilisation is the final process. Cure takes place, not in the therapy room, but in the life of the patient. Realisation of potentialities, ability to accept responsibilities, and face the inevitable anxieties of life are the test. Mature people can accept a little injustice in their lives, although there is a healthy degree of maturity which resents injustice to one's self and is able to fight against injustice to others. There is a maturity which accepts the conventions, and there is another maturity which seeks constructively to change them.

The culture changes. Some of the changes in values and standards may be the result of psychiatric findings and of the attempt to prevent illness by altering the pressures of society that seem to be the cause. The changes in culture are more likely to be caused, however, by more elusive changes in the climate of social relationships, and psychiatric studies could be the result, and not the cause, of these trends.

There is a publication called *The Lonely Crowd* by David Riesman and others, published by Yale University Press in 1950, which describes the changing American character. Three kinds of character are mentioned: Tradition-Directed, Inner-Directed, and Other-Directed.

The *Tradition-Directed* type of life existed in England before the nineteenth century and still exists in some Continental countries. The activity of each member of this kind of society is determined by obedience to well-recognised traditions. This works well until people rebel against it.

The *Inner-Directed* life leads to a behavioural conformity based on principles which still may remain active even when

the individual is moved to another setting and is illustrated by the stereotype of the Englishman maintaining his standards of etiquette in the tropics.

The *Other-Directed* character receives his approval, not by observing traditions nor satisfying his inner voice, but by anticipating the opinions and fashions of his own peers. He is the "conspicuous consumer" of material goods, and even his friendships are for display and not for his personal satisfaction.

The descriptions are elaborated and are discussed in relation to economics, politics, and changes in child-rearing patterns and family life. The parent in *Tradition-Directed* society has a pattern of life that is simple for the child to imitate, and both home and work are not so complex that children are felt to be a nuisance.

In the *Inner-Directed* life, there develops a choice of goals, with the capacity to seek new goals. Character training becomes an aim for the children, and a social distance develops between parent and child.

In the *Other-Directed* life there is "room at the top" for those who manipulate people rather than follow principles. Parents lose their certainties; children are scarcer; and, while not necessary for economic value, they have acquired an importance as representing the culture of tomorrow. Parents have no principles to offer; they may offer scoldings and token spankings; they try to reason with or manipulate their children; and they, in turn, are manipulated by their children.

It is important to recognise these changes because *therapy is relative*. It exists against the background of the culture to which the personality of the individual is adjusted, or to which it fails to adjust.

Much of our therapy was designed to treat people who broke down in the *Inner-*

Directed society—those with the strong superego. We are now having to deal with those who break down in the *Other-Directed* society—those with the weak ego.

There are also those who do not break down but who fit into a socially patterned defect which saves them from individual neurosis. For example, there is a present-day trend for young people to express their identity with one another by the wearing of outlandish clothes. Some young men in England adopted the styles of the Edwardian period and have given themselves the name of "Teddy Boys." It often appears that the wearing of this dress marks them out as potential delinquents, but it is more appropriate to look upon this trend as a group attempt to pass through disturbing phases with mutual support and to demonstrate, provocatively, their distinctiveness from the generation of their parents. It is curious that in so doing they adopted some of the features of the dress of their grandparents.

Therapy must alter in pace with the development of new cultural expression which influences personality through the various arts.

The therapist himself must grow. It is said that no therapist can take a patient further than the point that he himself has reached. I should like to return, however, to a discussion of some aspects of "suggestion." The process can be explained in two ways: sometimes "suggestion" is, figuratively, a lending of the therapist's personality to the patient—for a while; in other cases, the patient absorbs something from the therapist in a way that neither may be aware of. We can describe this process in Kleinian or Fairburnian terms as an incorporation or introjection of good objects. Such results go beyond an hysterical identification and may lead to permanent good results. Both these processes could be applicable to the miracle cures and faith healing in ancient and modern times.

As physicians, we like to understand what it is that we do. Most of us alter as we continue our work. We may do good work with the enthusiasm and interest that we give to our very first patients. It is an article of faith with me that we need constantly to renew our inspiration and that at every stage of our lives we do our best work with the growing point of our personalities.

Education's mental hygiene dilemma

In disputes relative to the place of mental hygiene in education, psychiatrists have stated:

"There is much talk about 'closing the gap' between education and mental health, but it is not often that a comprehensive program of education, in which mental health and child development concepts and practices assume their appropriate places, is described" (2).

This difficulty, which educators have encountered in their efforts to incorporate mental hygiene into programs of preparation for teachers and administrators, actually represents a many-faceted and pervasive problem which reaches into all areas and levels of education today: namely, (a) a time lag in applying what we now know about how individuals really learn, (b) confusion about the goals of education in a democracy, and (c) some confusion between methods and goals. Brubacher (5) has indicated, for example, that the organiza-

tion of "logical ideas" into subject matter compartments, the "teaching" of which was presumed to enable a person to think, decide, and act logically, came to constitute a major a priori assumption in the traditions of American education.

Until very recently, subject matter has been considered sacred and inviolable as a repository of what Harold Lasky has referred to as "our antiquity of knowledge and our knowledge of antiquity" (7). Only recently have educators in significant numbers had the temerity to suggest that, on the face of things, we have been falling far short of our goals, and that learning by direction or prescription has apparently not enabled us to predict when, as a result of such learning, people will give evidence of scientific thought and behavior, if possible. Recent data deriving from the behavioral

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sciences have helped educators to see that the methods by which people learn have much to do with the extent to which they can make their knowledge operational. It is now more generally believed that methods have to enable a person to understand what he is learning *at the functional level* if he is to make an emotional investment in that learning. Additionally, the learner's state of adjustment has been concluded to have meaning for what he is willing to learn or is capable of allowing himself to learn; hence the importance of motivation in learning.

Thus, while education's slowness in rendering mental hygiene principles functional in education can be traced back, in part, to the problem of the time lag in methodological change, it is more interesting and profitable to follow the problem out the other way to its implications for the preservice and inservice preparation of teachers, for in so doing it is relatively easy for us to appreciate the many dilemmas which teachers, administrators, and educational specialists encounter as they try to incorporate mental hygiene principles into curriculum planning, supervision, and interpersonal relationships. Following are some of the kinds of dilemmas which administrators, teachers, and college personnel face as they attempt to organize and implement their stand on behalf of preventive and curative mental hygiene. The dilemmas confronting administrators are largely procedural, although personnel actions constitute a significant problem area. Teachers' dilemmas, with reference to the mental hygiene problem, center around methods, relationships, and matters of self-assessment. The dilemmas for colleges seem to cluster mostly about recruitment and guidance.

(a) *The public pressure dilemma* is encountered by administrators and teachers where well-meaning parents urge the

schools to use instructional methods which are inconsistent with principles of mental hygiene. Examples: maintaining the status quo in educational methodology as though the last word has been written on methods, more homework for its sake alone, the use of report cards as against parent-teacher conferences, and the emphasis of the so-called "tough" courses, all of which seem to ask that we adjust the child to the curriculum when we know that it is equally—if not more—a case of adjusting the curriculum to the child.

(b) *The selective-employment dilemma* is caused both by the teacher shortage and by the fact that we have, at present, insufficient criteria with which to predict success for any given teacher. As practice teaching experiences progressively organized become more effectively interwoven with theory and the use of materials, this problem may be eliminated, but for the present, administrators have very little opportunity to be really selective in the face of need and have difficulty in weeding out any but the very obviously emotionally disturbed applicants for employment. The importance of this dilemma can be partially assessed by a statement of the basic policy of the Michigan Society for Mental Health, which reads in part:

"The primary focus of the program would be directed toward classroom teachers because of the length and intensity of their contact with children and the real and potential influence the teacher has on the individual child and the group climate" (8).

Barbara Biber, the director of research for the Bank Street College of Education, has stated:

"... and yet, on the basis of experience, we must honestly report that there are many instances in which young, well-prepared teachers find it difficult to stand up to the impact of their first jobs, espe-

cially where the teaching conditions, the quality of administration, the life backgrounds of the children are in sharp contrast to what they experienced in their own backgrounds or during the training period" (2).

Thus, one can see that the selection and retention of capable teachers is ultimately of importance to the mental health of students.

Related to the administrator's selective-employment problem is (c) the *tenure dilemma*, an enigma for all administrators who face public and professional censure whenever they attempt to separate employees who prove in time that they are not professionally competent because of personality disorders. One need not press his imagination too strenuously to picture the needless multiplication of interpersonal problems in cases where a disturbed teacher and a disturbed child have been thrown together in a classroom situation.

Relative to the needs of students in many communities, teachers, administrators, and other educational specialists run head-on into a (d) *referral resources dilemma* in cases where they have a really disturbed child on their hands only to find it difficult, time-consuming, or impossible to secure treatment services within a reasonable distance, although Viola Bernard indicates that some of the mental hygiene problems in public schools can be traced back to matters of teacher preparation. She has written with reference to this specific matter:

"The best of mental health inservice programs for teachers is handicapped by the original preservice training, if this was too much at variance with mental health concepts" (1).

Yet, on behalf of teachers, it seems only fair to state that the (e) *teacher preparation—teacher practice dilemma* is a very serious

problem for teachers who are asked to teach in a manner almost totally different from the manner in which they were taught. The problem is similar to that of the parent raised in accordance with the "woodshed" school of discipline who is now encouraged to use permissive techniques in rearing his own children. One can appreciate that this problem would be intensified in the case of an insecure teacher who used instructional techniques as a part of his or her defensive armament.

However, there are cases where teachers are willing to try new ideas, only to be blocked in their efforts by traditionally oriented or fearful administrators. Bernard has stated, with reference to this problem:

"Teachers far exceed the administrators in their readiness for and capacity to merge mental health concepts, as taught by clinicians into their own educational approach" (1).

Thus, an (f) *innovation dilemma* is present for the teacher who is aware of the many ways in which mental hygiene can be worked into curriculum and made a dynamic part of the educational experiences of children, yet who must adjust to an administration which is fearful of looking at curriculum experimentally. Knowing what we now know about how children learn best renders the teaching situation very trying if we are limited to "second best" approaches and resources.

Relative to Bernard's statements, Robert E. Bills (3) of Alabama Polytechnic Institute has postulated in his studies on perceptual psychology that administrators' personalities have an effect upon the personalities of their teachers. He indicates that the effect is manifested in their security operations and is therefore measurable. Of importance here is Bills' point that administrators having what he calls "minus-minus personalities" (insecure, negative, anti-so-

cial, fearful, and authoritarian) bring out similar traits of behavior in their teachers, whereas "plus-plus personalities" (secure, positive, sociable, confident, and democratic) elicit similar traits of behavior in their teachers. The prior works of Polansky, Lippit and Redl (10) on "behavior contagion" would seem to support Bills' thesis.

Of course, it has only been within the last decade or so that we have begun to define our mental hygiene terms operationally, and until this goal has been achieved, it will be difficult for prospective teachers to really apply what they are now only beginning to understand. This (g) *operational definition dilemma* has other important ramifications. For example, until concepts have been made operational, it will be difficult to establish real, attainable goals. And until we have specific goals, it will be likewise difficult to establish criteria for measuring or evaluating progress toward goals.

Perhaps of more pressing concern to teachers is the (h) *control-expediency dilemma* which vexes most new teachers and a fair percentage of experienced teachers, at least at the beginning of each semester. In an effort to maintain outer control over student behavior, teachers very often fly to the use of expedients in the form of coercive techniques which prove, in time, to be precedent-setting. The fear that they will lose control over the behavior of students is compounded by the fear that they will therefore be rated down as to competency by their peers and supervisors. The resultant anxiety not only renders it difficult for them to think of a mental hygiene approach (the development of inner controls over impulsivity) but renders the very use of such an approach highly threatening. The end result too often is that they resort to a type of discipline which is coercive, repressive, anxiety-producing, and actually the

opposite of what should be used—first, in terms of the developmental nature of growth and, consequently, of learning and, second, in terms of what we believe the goals of education must be in a democracy.

Speaking of the problems which teachers face, R. H. Felix has said:

"Even without the extra stresses caused by the cultural growing pains of today's society, the emotional environment in which teachers work holds considerable strain and tension. The psychological interaction involved in teaching a roomful of lively youngsters is not easy to handle hour after hour and day after day. In addition, teachers have to adjust to administrative direction from above and to the pressures of parental and public opinion from without, and, more than in most occupations, the teacher's job is likely to carry over into his personal life" (6).

Germane to this observation is the fact that our college courses have been designed to orient prospective teachers to the symptoms of maladjustment in children, however, without equipping them with workable criteria or techniques for assessing the need for referral in individual cases. Even the preparation of counselors is notoriously weak in this regard. This (i) *symptom assessment dilemma* could be materially reduced if we spent more time with prospective teachers in their use of teamwork techniques in evaluating children's adjustment and need of referral for treatment. For example, since we know the classroom teacher cannot be a clinician, why not encourage her to invite the school psychologist and/or any other concerned specialist to observe the problem in her room, much as a medical examination team conducts a group diagnosis? As a member of a team interested in reducing blocks to learning, she would be less likely to interpret referral as any indication of her lack of ability or qualification as a teacher.

The teamwork approach would enable all parties concerned to consider tentative solutions for problems in their real setting whether they involved referral or not. One additional benefit deriving from such collaboration would be that the school psychologist and other specialists who, unfortunately, orient their services around the administration of clinical measurements would, instead, structure their contribution around: observation; thinking through the problem in its real setting; and utilizing tests more appropriately and creatively with resulting economy of time and effort. This approach should help prevent the members of the team, who ordinarily make a creed of individual differences, from falling victims to the stereotype of normalcy in which the slightest "differences" elicited through diagnostic material are blown up into a type of significance which does not square entirely with the facts of individual differences.

Since educational methodology is undergoing a basic shift in both methods and goals, one can appreciate the difficulty teachers oftentimes face, what with their having one foot in the "emphasis-on-content school" and the other in the "emphasis-on-the-child school." We do not as yet have sufficient "know-how" to enable us to jump into the "emphasis-on-the-child school" with both feet, although that day is approaching. The use of the problem-solving process would appear to be a step toward such a goal. Meanwhile, older teachers whose preparation gave eminence to subject-matter, plus those new teachers whose abilities and/or personalities do not permit them to function in this new role with ease, face an almost unavoidable (j) *content versus education of the child dilemma*. Very often, these teachers are inclined to make an obeisance to mental hygiene concepts by including, along with

other content, a unit on mental hygiene, as though it could be conveyed operationally as a discreet block of knowledge. Their disappointment, when perceiving that neither the attitudes or behaviors of their students have been perceptibly altered by such units, is understandable but lamentable.

With respect to the fine work of Ojemann, Levitt (9) and others who substantiated the value of teaching a causal analysis of behavior as against a surface analysis (praise and blame), content, no matter how dynamic, would seem to be second in importance to instruction which, through pupil-teacher planning, makes greater allowance for the needs of children.

Another problem encountered by novices as well as experienced teachers involves the (k) *identification-expectancy dilemma* wherein the teacher identifies with handsome or precocious children and expects performance which may not correlate too well with their capacity. Teachers have been known to project expectancies out of their own experience, forgetting that they are generalizing from the point of view of a person who was among the top 10 or 15 per cent of his high school graduating class in ability, performance, and conformance. Bingham and Moore (4) referred to this phenomenon as "halo effect." Other writers have indicated that teachers, as a group, emanate from the middle class and that they tend, in cases, to generalize or project from a basis of their cultural backgrounds. It seems reasonable to submit that this rather simple practice of attributing ability to becoming individuals is much more common. Obviously, such expectancies can place undue strain upon children, all or most of whom seek approval or love through conformance. This practice involves anxiety for both the teacher and the student at the point where the child cannot come through

for the teacher and gives ample evidence of the teacher's need of accurate data on the ability of individual students and of his need to use it.

Stephen Withey (13) has found in his studies of adolescent boys and girls that they want and need both freedom and limits. For teachers and parents this (1) *freedom versus limits dilemma* presents problems which, in analysis, highlight the developmental nature of both growth and learning. Freedom to make decisions for one's self—to try one's wings—is certainly a prerequisite to the assumption of adult responsibilities in a democracy. In terms of the obvious goals of education in a democracy, individuals need practice in developing inner controls over impulsivity. How are they to get the necessary experience unless they have commensurate freedom? This dilemma is much more severe for teachers who believe they can teach by prescription, who emphasize subject matter over the unique individual, and who do not understand the developmental relationship between growth and learning. Yet for all teachers, the problem of defining what is too much freedom and, conversely, too much control presents a dilemma which can be resolved only through realistic preparation, a well-thought-through philosophy of education and experience.

Not all mental hygiene dilemmas take place on the operational level, however. There exist theoretical dilemmas as far as psychological theory is concerned. An (m) *theoretical orientation dilemma* which plagues many teachers can be partially recognized in their defensive handling of disturbed children, their comments in advanced classes, and their anecdotal record write-ups. There appears to be just enough confusion on their part to enable them to make some rather far-fetched connections between a "disturbed," "neurotic," or "mal-

adjusted" child and that child's expected behavior. For example, many of them assume that a poorly adjusted child has something "sexually wrong" with him. Hence, they fear the development of any friendly ties with him lest his problems erupt with subsequent embarrassment to all parties concerned. This fear seems to be especially intense in the case of female teachers and male students and in the case of male teachers and the somewhat effeminate male students.

If we at the college level were more effective in helping teachers to understand that confused emotions lie at the core of a disturbed individual's personality, that sexuality is but one of many peripheral behavior areas in which the problem manifests itself, and that feelings constitute the center of the difficulty, we would help teachers to resolve such a dilemma, thereby enabling them to function more adequately in the role of guidance.

The references in this paper to the kinds of changes which are taking place in education today point ultimately toward the fact that teachers as process persons must be skillful and perceptive in matters of interpersonal relationships with peers as well as with children. And, as education becomes less and less a place for an insensitive person, it becomes more and more a place where teachers must continuously assess themselves. It is not enough that they shall evaluate themselves in terms of such psychological phenomena as counter transference (12) or in terms of such sociological concepts as group dynamics and group process but in everyday operations as they: look at curriculum experimentally; teach on a basis of individual differences; incorporate children's needs, interests, and common experiences into the curriculum; use pupil-teacher planning; function in the role of guidance; and extend class time into

larger blocks so as to facilitate all these techniques. Teachers themselves would probably agree that to function most effectively in all these areas, they would have to be nonthreatening personalities using noncoercive practices.

However, by what exact criteria are teachers to assess themselves? In terms of what specifically defined operational goals can they evaluate *their* progress as teachers? This is the (*n*) *self-assessment dilemma* which teachers face. In view of the fact that education is halfway between a traditional form and content and something new in form and content, teachers have great difficulty in selecting one or another set of goals against which they can evaluate their professional development.

Relative to matters of teacher self-assessment, Fritz Redl (11) has presented an excellent reason why teachers and all adults should assess their relationships with children. Speaking particularly of defiant children, he has said:

"The problem of 'defiant youth' is complicated by the fact that the adult generation generally lacks conceptual clarity in discussing the issues involved. Furthermore, 'defiant' behavior by children seems to bring out the worst in adults, provoking them to react with their own feelings rather than with deliberate thought."

It would seem that we must help teachers to assess their professional behavior against the fabric of their philosophy. This means that we must help them to develop a philosophy or at least a value frame of reference relative to the education of children. Such a frame of reference must incorporate our basic democratic beliefs as to the worth of the individual, equality of opportunity, and the consent of the governed. Throughout their preparation, teachers should have some means of becoming acquainted with

the findings of qualified research which throw new light on the learning process. Out of these concepts and data, education must formulate and reformulate its goals so that teachers, in terms of the kinds of techniques mentioned above, can determine how effective they are as human beings in helping individual human beings to acquire learning.

Finally, colleges of education face both a teacher recruitment and a student guidance problem which, for the sake of convenience, might be called the (*o*) *teacher selection dilemma*. Colleges of education have no really dependable criteria for predicting teacher success at present. An "A" or a "C" grade student might be either effective or ineffective as a teacher. This problem quite likely relates to the problem of changing emphases and goals already mentioned. In any case, we have as yet no qualified data relating to a prospective teacher's aptitude for group work in education. We also lack definitive studies of teacher attitude and values. Such studies must be longitudinal so as to provide us with the kinds of data which will help us see the differentiation between students who enter colleges of education and students who enter the other colleges and schools. We do not know what differences exist between students who stay in colleges of education until they graduate and students who drop out of teacher preparation programs. We do not know nearly enough about the differences between teachers who are flexible and adaptable in their use of methods, who warm up to kids, who enjoy sharing the aesthetics of the learning process with them, and who are nonthreatening most of the time and, on the other hand, teachers who are inflexible, dogmatic, judgmental, punitive, and threatening to children most of the time.

It is not enough to state that such prob-

lems are psychological and have to do with personality growth and development. The college of education cannot be a clinic for therapy. We have to know, in terms of their influence upon the mental health of children, just where these various types of teachers belong in the educational scheme of things, or if they do not belong at all. Of course, a potentially capable person who has minor problems to work out should have available help and should be encouraged to use it. However, there are cases where the prospective teacher might well be guided into other fields of work for the good of children in general.

SUMMARY AND CONCLUSION

In summary, it might be said that these dilemmas which teachers, school administrators, and college personnel face tie in with the mentioned lag between how we prepare teachers to teach and what we now know about how children learn. Other factors which impinge upon education's mental hygiene dilemma involve: (a) problems relating to teacher personality, (b) a need of predictive instruments, and (c) a need for realistic guidance in colleges of education. Since teachers in a real sense "guide" the learning of children, the teacher-child relationship can be seen as crucial to what we might term "the mental hygiene approach," which should be, after all, just good teaching.

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Transitional programs for psychiatric patients

Because of improved treatment methods, the number of patients being discharged from mental hospitals has been consistently increasing during the past five years. Experience with hospitalized patients indicates that there is a definite need, varying with the individual patient, for transitional programs to facilitate the change from institutional living to community living. It is clear that it is one thing to bring a patient to the point at which he is well enough to leave the hospital but quite another thing for him to remain out. It is likely that these transitional programs may be applicable to many patients who have not been hospitalized so that they can be maintained in the community, and hospitalization can be prevented.

The treatment goal of the mental hospital is to restore the patient as quickly as possible to a level at which he can function effectively in the community. To

that end, chemotherapy is utilized extensively so that psychotic symptoms may be quickly brought under control, making the patient accessible to the rehabilitation therapies. Instead of expending most of their time and effort in coping with psychotic symptoms and behavior, the hospital staff then has a greater opportunity to help the patient develop his ego strengths and personal assets. Therapeutic activities and programs of a transitional nature are designed to simulate as closely as practicable real-life situations which the patient will encounter outside the hospital. These situations involve work, social relationships, and community activities. Another aspect of the patient's life outside the hospital is his own responsibility for maintaining prescribed medication schedules,

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whereas in the hospital this is the responsibility of the nursing service.

Three important factors to be considered in setting up a transitional program are: objectives, incentives, and implementation. Some of the special programs at Brockton VA Hospital will now be described to illustrate these considerations.

The Member-Employee Program (1, 2) was originally a domiciliary program adapted for the NP hospital by Dr. Peter A. Pfeffer in 1952 at the Perry Point VA Hospital. One of the objectives of this program is to prepare certain selected patients for the community vocationally so that they will be productive and self-supporting. A number of Member-Employee positions are established in the hospital. These positions are set up in accordance with Civil Service job descriptions and job specification requirements. The Member-Employees work a full eight-hour day under the supervision of a regular employee. Although their pay is only one-third of the regular pay for the job, they are supplied with housing in their own quarters, not on hospital wards, meals which they eat in the personnel dining room, and medical care, including medication. These fringe benefits probably more than compensate for the two-thirds pay they do not receive. A counseling psychologist is in charge of the program and is responsible for carrying out the recommendations of the Medical Rehabilitation Board, which approves the patient's admittance to the program. Patients are presented to the Medical Rehabilitation Board by their own treatment teams. On the basis of the medical and psychiatric history, social service report, psychological testing, vocational counseling, and observations of rehabilitation and nursing service personnel, the board make its decisions and recommendations. There is usually the

limitation of one year on the program, during which these objectives must be met. Every three months, the Member-Employee is brought before the board for interview and review of his progress. Member-Employees are assigned to every aspect of hospital operation. They work in the laundry, on the grounds, in building maintenance, in the offices, in nursing service as aides, etc. The counseling psychologist holds individual counseling sessions with each Member-Employee every two weeks and also conducts group sessions with them when they collect their pay every week. A social worker assigned to this program full-time meets regularly with each Member-Employee to discuss family relationships and prospective living arrangements. After the Medical Rehabilitation Board has decided that a Member-Employee has received maximum benefit from the program, the counseling psychologist assists him in obtaining a job, if this help is needed. One of the most valuable aspects of the program has turned out to be follow-up within the community of patients discharged and placed in jobs (3, 4). This is done for a period of six months or longer, if necessary. Contact with the employer as well as the ex-Member-Employee has averted many crises which would have resulted in rehospitalization. In four years, 282 patients have been assigned to the Member-Employee Program, and 198 have been discharged. Of these, 40 had to be rehospitalized. However, 22 of the 40 are now back in the community. A cost analysis of the program in 1957 indicates savings of over \$600,000 to the government. To date, these savings would probably amount to well over one million dollars at Brockton alone. To this may be added savings achieved at 37 other Veterans Administration hospitals which have adopted this program.

A second transitional program, for long-term chronic patients who have no families or homes to return to and who are not considered prospects for vocational rehabilitation, is the Foster Home Cottage (5). This program is administered by the Social Work Service. The cottage is a 10-bedroom building in which each patient has his own room, closet, and bureau and is responsible for his own housekeeping. The two main meals are brought over from the hospital kitchen and are served in a combination dining-living room. There is a small kitchen in the cottage in which breakfast is prepared and which is used for snacks at night. Patients shop in the nearby markets for food for these snacks. With the help of a female nursing assistant acting as "house mother", the emphasis here is on resocialization, habit training with regard to eating and grooming, and de-institutionalization. When the patient is considered ready, he is taken on visits to foster homes where ex-patients are living. He probably knows some of these patients, talks to them and to the foster mothers, and has a chance to see for himself the advantages of this kind of living over institutional living. Eventually, he asks to be placed in a home himself. Group meetings are held weekly with the social worker in charge of the program to discuss problems concerned with the cottage itself and to deal with hospital-separation anxiety or anything else they want to bring up. Group parties, picnics, and trips to points of interest are arranged in co-operation with hospital volunteers. A hobby shop adjoins the cottage, and extensive gardening is done by the patients on the grounds. Courses are given in simple food preparation by dietitians, personal hygiene by nurses, and elementary home repair by engineering personnel. In a period of three years, 40 patients have been dis-

charged to the community. Only three of these have been readmitted for psychiatric reasons. These results become more impressive when the patient's average age of sixty years and average length of hospitalization, 15-20 years, are taken into account. It may be added that the hospital-wide Foster Home Program has placed a total of 250 patients in the last four years with a readmission rate under 10 per cent, considerably lower than the hospital average for patients not in this program (6).

A third type of program, also initiated by Dr. Peffer at the Perry Point Hospital, is the Ceramics Project (7). The objective of this program is to motivate regressed apathetic patients to engage in some productive activity at a sub-vocational level, particularly when other activity programs have not been able to achieve this. The financial means for this program were supplied by a subcommittee of the Veterans Administration Volunteer Service. Contributions were obtained from the veterans' organizations and all funds, purchase of supplies, sale of products, and the nominal pay for patients participating, is handled by this subcommittee. The project consists of a co-operative group activity in which no single patient makes a complete product. Interaction is promoted by dividing production into phases with groups of patients working on each phase under the direction of an occupational therapist. In the process of working next to each other, handing tools and materials to each other, taking coffee breaks, etc., the patients inevitably learn that relating to others involves some satisfactions as well as anxiety. Finally, the finished product and the comments of visitors about the ceramic goods give these patients much-needed feelings of achievement and self-esteem. The token wages, graded according to the level of work performed, pro-

vide an added incentive. In 1957, 74 patients were assigned to this project; 15 were discharged from the hospital; 19 were promoted to higher level industrial therapy assignments; 28 remained in the program, showing some improvement, and 12 were discontinued because of physical illness or lack of improvement.

The Patient Government Program (8) which is conducted on most of our hospital wards has a primary objective of giving the patients an opportunity to communicate their group opinions, wishes, and needs to management. It provides a type of experience similar to that of a member in any civic organization. The patients elect their own ward officers and representatives to a central council. Ward meetings are held weekly with the team clinical psychologist present as adviser and resource person. Council meetings are held every other week. Frequently, delegations are instructed to meet with the manager, director of professional services, or chiefs of services to make requests or obtain information. They are always received with respect and courtesy by these officials. Patients form their own committees to take care of ward housekeeping, to welcome and orient new patients, to organize recreational activities, and to contribute their services to the hospital and the community. They have made toys for children's institutions; they push wheelchair patients to church and to the theater; they have contributed money to the local child guidance clinic; and they have looked into ways in which patients can be helped after discharge through such organizations as Recovery Incorporated. Many patients derive individual benefit from their work as patient government officers and committee delegation members in the form of increased self-assurance and ability to express themselves more effectively.

There are a number of patients for whom it is essential to continue on maintenance dosage of the ataractic drugs in order to keep their psychotic symptomatology under control. Without supervision, some of these patients neglect their medication. This has proved to be an important factor in a high proportion of our rehospitalizations. In selected cases, follow-up visits to the hospital are scheduled for up to one year after the patient has been discharged. During these periodic visits, the patient is seen by his team psychiatrist who checks on his clinical condition and his adherence to prescribed medication (9). At the same time, the patient has an opportunity to discuss with the psychiatrist, social worker, vocational counseling psychologist, or clinical psychologist, who are familiar with his case, any problems or difficulties he may be having in his post-hospital adjustment. For some patients, supportive psychotherapy is continued for a limited period before termination or referral to an outside therapist is accomplished. The patient thus receives needed support at the critical period when he is attempting to adjust to major changes in his environment. In these ways, the outpatient follow-up program has helped to anticipate and prevent relapse.

In summary, it is felt that the success of a transitional program depends upon: definite objectives for what the program is supposed to achieve for specific types of patients in terms of their post-hospital living; well-planned means for implementing the program, and inherent incentives for the patients to participate in something that is meaningful to them.

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Some effects of stealing in a college dormitory

The purpose of this paper is to explore the ways in which continued stealing in a dormitory of a girls' college brought about reactions of fear and unreasonable argumentativeness in a group of students who served on the dormitory government. Ultimately, this led the house council to set aside student self-government in favor of authoritarian and punitive methods. These methods were opposed by the administration and misunderstood by the dormitory students themselves who became increasingly critical and suspicious of each other and of the administration. After some months of unsuccessful efforts to stop the stealing and to ease the tension in the dormitory, the administration decided to handle the situation by appointing a psychiatric consultant to the college. Working with

the members of the house council, the psychiatrist helped to re-establish harmony among them. This resulted in a different and more reasonable attitude toward stealing. But, more than this, it set new goals for student government which were more compatible with the expectations of the students themselves and which fitted in with the aims and wishes of the administration.

The college in which the above events occurred requires courses in developmental and social psychology. These courses are designed to help the students understand themselves and the behavior of children in classrooms and to help them become aware of some of the causes of deviant behavior. A therapeutic or clinical attitude toward their pupils rather than a conventionally punitive one is, therefore, not foreign to them. Most of these students come from middle-class backgrounds. They live in dormitories housing 50 to 100 girls

who are supervised by housemothers and by student house councils. The college administration was liberal in its attitude toward student government and encouraged freedom and autonomy in the conduct of student affairs. As a result of this, the goals and privileges of the campus government (including the student council, the officers of the student body, and the individual class officers) were clearly defined, but the function of the house council was vague and uncertain.

In recent years, there had been sporadic thefts of money from dormitory rooms, particularly from the largest dormitory, comprising nearly 100 girls. In accordance with the ideas emphasized by the administration, the handling of this difficulty was left to the house council, which had, however, no precedent to follow. Because of this, the council was reluctant to approach the problem and, instead, awaited administrative action. As the stealing increased in frequency and magnitude, student dissatisfaction manifested itself by a defiance of existing rules, by obvious cliquishness, and by overt dissatisfaction with the college.

In the year of this study, the dean and the president, separately and then jointly, met on several occasions with both the house council and the students of the dormitory. These efforts on the part of the administration to co-operate with the house government were resisted by the students, who demanded that the administration itself assume responsibility for any action taken. The dormitory soon broke into cliques, each with its suspects. The girls' attitude toward them was to catch them as soon as possible and then to punish them. The house council itself shared this attitude and was either unable or unwilling to think in any terms except those of prompt, severe disciplinary action against the unknown but suspected culprits.

Finally, at mid-years, a girl who had achieved a somewhat questionable reputation, both socially and academically, was found by a member of the house council going through a bureau drawer in another girl's room. The students in the council demanded immediate action, and the girl was brought before the officers, the council, the president, and the dean. The house council demanded expulsion, but the administration was unwilling to accede to this because of insufficient evidence. To this decision the house council reacted with outspoken hostility, accusing the administration both of procrastination and of favoritism. Relations between the administration and the council members became more and more strained, and further co-operation between them seemed impossible. It was at this point that the president decided to call in a psychiatric consultant—the author—to study the situation from his point of view and to make recommendations.

In the first conference with the president, the consultant was told that the dormitory students were angry, defiant of rules, hostile toward the housemother, and were ready to persecute the suspected culprit. In addition to this, the house council had become more and more secretive and had lost contact with the girls themselves. It was this attitude that the president and the dean found themselves unable to overcome. Furthermore, in the opinion of the administration, the behavior of the girls and of the house council suggested that the disturbance in dormitory life did not result wholly from dissatisfaction over stealing. It was for these reasons that the administration decided to try a new approach.

The psychiatrist's first observation was that the role and authority of the house council was far from clear. This observation corresponded to that of Freidson (3) who found in a sociological study of 600

colleges that the dormitory councils usually lacked tradition, had no defined point of view, were wanting in *esprit*, and occupied a position subordinate to the student government. They were, therefore, inefficient. All of these qualities, in varying degrees, were present in the house council under study, and, consequently, the administration could not rely upon the council to carry out its responsibilities. Because further contact between administration and students undoubtedly would repeat past failures and because the students' open mistrust and anger seemed to be growing, it appeared best for the consultant to work directly with the members of the house council without further contact with the administration.

An initial meeting with the psychiatric consultant was arranged by the administration, and the house council met with him in a lounge. The council itself was composed of 11 students: one freshman, two sophomores, four juniors, and four seniors, elected annually by the house. The officers and a few other upperclassmen had served before, and these members were the working nucleus of the group. It met twice monthly in closed session. Liaison of the house council with the housemother, with the administration, or with the students in the dormitory was either lacking or ineffectual.

The psychiatrist opened the first meeting by stating that he had been asked by the president to evaluate the problem of stealing in the house. This fact was obviously of great interest to the council. Therefore, it seemed best to work with them. The group was then told by the psychiatrist that, in his experience, group feelings often become so strong that they interfere with solving a problem. He told them that he was not an expert on student government, but that he could be of help to them in working

out some of their feelings about their present situation. It was then agreed to have further meetings at which attendance would not be required and in which the matters discussed would be confidential.

The immediate reaction to the plan outlined by the psychiatrist was angry resistance to it and renewed hostility toward the girl whom the group believed to be guilty of stealing. In the face of defensive emotions, a group such as this one will often lose its identity; then, further work with it becomes impossible until the emotion has subsided. Both Berman (1) and Mann (7) have observed that the very reason for the existence of a group can be lost in the emotional reactions among its members or between the members and the leader. In the case of the group under investigation here, these reactions were characterized by fear, anger, and a kind of unreasonable, stubborn argumentativeness. What unity they exhibited was based rather on defensive hostility than on any common rational purpose. Under these circumstances, the group could not picture the psychiatrist as a neutral or as one who could help them. He took great pains, however, to be consistently uncritical and to play the part of an observer rather than a participant.

During this meeting, the students gradually gained some insight, which was best expressed by one of them who commented, "Isn't the real trouble that we can no longer talk together?" But, of course, they soon returned to the theme of the "bad" student who was thought to be guilty of stealing. Even though they lacked evidence, they were convinced of her guilt and sure that she should be expelled from college. It became apparent that the students, led by the seniors—the class to which the suspect belonged—were basing their judgments on other factors which had little to do with

stealing. They were united in their condemnation of her for alleged promiscuity, for frequent lying, and for cheating on tests. They also criticized her for hoodwinking her teachers and for "leading naive freshmen into her sphere of influence." In the council's opinion, the psychiatrist should have been spending his time with her rather than with them. But hostility toward this girl was tempered by certain extenuating facts about her background, and these aroused their sympathy, especially the fact that she was an adopted child. On the other hand, they believed that the dormitory students expected them to demand expulsion, and, if they did not, that they themselves would be condemned by the students.

At the next meeting, the fear and anger which had been previously observed was directed more at the administration than at the suspected girl. The council seemed to feel that the administration had let them down, and that nothing was going to be done to support them in their stand. Furthermore, the group meetings themselves were looked upon as a means of delay and appeasement, and the council seemed to think of the psychiatrist as a person employed by the administration to punish them by exposing them.

During the next two meetings, more general and personal topics were discussed. The housemother was pictured as a well-meaning but inconsistent tyrant who was depriving them of their freedom by usurping many of the duties of the house government. They were divided on how to deal with this housemother. Some girls believed in open defiance; others wanted to bring her into the group. In addition, the group discussed promiscuity, cheating, drinking, and "how far to go with boys." In the first meeting, these subjects were connected with discussion of the "bad" girl, but at this

time these topics had begun to be discussed as individual concerns of the group members.

As the psychiatrist became less of a threatening figure, the group began, tentatively at first, to discuss proper conduct in the college, specifically how far they should go with boys and how much they should drink. These concerns were obviously of great moment, and the psychiatrist was careful to include all members of the group in the discussion so that those contributing most to the discussion would not feel exposed or judged. In these discussions, the girls seemed to be experimenting with relinquishing their previous defensive attitudes but were reluctant to do so until they trusted each other and were clearer about their relationship to the psychiatrist.

The sixth meeting was preceded by an event which proved decisive in terms of group unity. In the course of the meeting, an episode was described by a member of the group about the behavior of a girl on a week end visit. This girl had blanket permission from her parents to go wherever she pleased on week ends, with the exception of registering at a hotel. On the preceding week end, she signed out for home. The vice-president of the council became suspicious, however, because of remarks dropped by friends, and asked her if her parents were going to be there. The student was evasive, and the member of the council made her suspicions known to the housemother, who found that the girl planned to have a large mixed party at home in her parents' absence. This was reported to the dean of students who saw the girl, not with the idea of stopping her, but rather of helping her so that she might not place herself in a compromising position. This situation was then worked out satisfactorily between the girl and the dean.

The reaction of the group to this was

divided. The younger members, particularly the sole freshman representative, felt strongly that the members of the council and the housemother had no right to be suspicious of this girl and that supervision of extracampus activities was not a function of house government. But the vice-president and several others felt just as strongly that it was the place of the house council to see that no girl, through indiscreet behavior, bring disgrace on the house. Most of the group agreed that the girl in question had not shown good judgment and that the dean had been of help. In other words, most members of the group were now defending a girl and the administration on grounds similar to those for which they had previously condemned another girl. Some unity in the group then appeared for the first time, but it remained precarious because there were still two opposed points of view. One element, led by the vice-president, insisted on punishment, whereas the other element, led by the president, was for tolerance and guidance. A cleavage therefore occurred, and the vice-president and her followers withdrew from the group meetings. This released the tension, and the remaining members were able to work together in relative harmony. But the key problem that remained for the council to solve was the division of authority between them and the housemother. To assume the major share of responsibility, they would have to act with independence and decisiveness toward realistic goals.

In the next meeting, they were ready for this and turned to the psychiatrist, asking how they could behave as he had behaved toward them. They wished to meet with the students in small groups to take them into their confidence and to exchange ideas with them about house government. They decided that each member of the council would meet in an informal weekly

session with the 15 to 18 students occupying a dormitory corridor. The psychiatrist felt that he could then be of most use—in accord with his original formulation of goals—by supporting them in the difficulties they expected to encounter in these meetings. Some students in the house council were prepared to meet hostility and condemnation for their lack of success; other students were concerned about the housemother. At the end of this discussion, the psychiatrist suggested that the fears expressed by the council members revealed more about their own personal difficulties than about what was going on in the dormitory. The group accepted this with evident relief.

At the next meeting, most of the group said they had been surprised by the uncritical attitude of the students at the corridor meetings and at the absence of concern about stealing. Attendance at the meeting had been good, and the students had thought the meetings were a good idea and were willing to continue them. The members of the house council were concerned about the lack of real understanding of the goals of house government by the dormitory students. The group decided that future meetings with the students would be structured around discussions of the present constitution of the house council. The purpose of the student leader would be to stimulate discussion so that ideas obtained from these meetings could be included in an eventual revision of the constitution. They hoped that these meetings would lead to a clearer delineation of house council responsibilities in the affairs of the house. They further hoped that a new constitution, drawn up at the wishes of the house, would help eliminate the housemother's previous interference in house affairs. Naturally, the efficacy of this approach depended entirely on the student leader's skill at putting the

students at ease and inducing them to talk freely in an unstructured way. The psychiatrist had the impression that, for the most part, the corridor meetings were more structured than not but that they did fulfill the important purpose of stimulating student interest in house government.

During all the meetings, the council members had continued to be angry at the housemother who, to them, seemed to be obstructing their plans. In early meetings, they talked of how impossible she was and for this reason, any plans to deal with her reasonably would fail. After the group split, the remaining students began to discuss ways of including the housemother in their plans without surrendering any of their own autonomy. They feared that she would dominate any meeting to which she was asked and that, as a result, they would not be able to put across their own plans. At this time, the psychiatrist suggested that it might be wise for the officers of the council to plan a meeting with both the housemother and the dean to explain their plans. He carefully explained that the dean would support them in what they were doing and that the housemother would not interfere if she understood that the administration was in favor of the plans of the house council. This meeting was resumed with the house council, the dean, and the housemother all present. At this time it seemed obvious that the group had abandoned their previous defensive rigidity in favor of a more flexible and workable idea of student government. This permitted them to see fellow students and the administration in less critical terms, and they were free to begin relating to them as a governing body with definitive goals. As this occurred, their need for the support of the psychiatrist decreased, and, by mutual consent, the meetings ended after a total of ten 90-minute sessions.

DISCUSSIONS AND THEORETICAL CONSIDERATIONS

Before continuing with a specific consideration of the case itself, it may be helpful to make some general comments from a psychodynamic point of view about possible limitations of student government groups in the college community. Because of the needs of late adolescence groups with divergent goals, conflicting ideologies and varied social composition assume importance in the college community. Many of these groups have little social impact; others contain interest and significance for the whole student body. Student government is usually among the foremost in its widespread campus significance. Furthermore, student government is unique in that the maturity of its participants reflects the social maturity of the students as a whole. But, no matter how effective these student leaders seem in their activities and no matter how high the standards of the students may appear, it can be assumed that the social standards of students are still partially organized around the rather primitive concepts of right and wrong characteristic of childhood and early adolescence. Consequently, under difficult conditions, the performance of college government groups can easily be marred by punitive impetuosity or ineffectual apathy unless established precedents or effective faculty assistance aids student leaders in administering their peers with responsibility and tolerance. In addition, and this is perhaps the most pertinent factor for the purposes of this paper, participation in student government is an intense group experience, and the end value of any group experience is dependent upon the early development of mutual trust and common goals among members. In a student government group, as contrasted with a therapeutic group, the development of this

trust not only relies upon the ease with which members accept each other but is also contingent upon the ease with which the members themselves accept the authoritative role of a government member. If the development of this mutual trust becomes obstructed by reactions of fear and defensiveness in the group from either the reaction of the members to each other or from community apathy or opposition, the experience itself becomes a mere repetition of past conflict and not progress in civil education.

The case discussion which begins this paper makes it clear that student responsibility in the management of dormitory affairs had not been previously developed and that recent efforts to initiate student interest in self-government had come primarily from the administration and not from the students themselves. The attitude of the administration contrasted sharply with that of the housemother, who believed that direct administrative action of a punitive nature was necessary to put an end to the stealing. Thus, the house council was caught between two methods of dealing with stealing. Through their behavior, they had begun to show the administration that they were in no way ready to assume full responsibility for the management of their own affairs. But they were unable to turn to the housemother because she seemed to be trying to usurp their freedom. As a result of these conflicting attitudes, they were unable to follow with consistency either the approach of the administration or that of the housemother. Instead, they showed their resentment by becoming more indecisive and secretive in their actions.

In the meetings with the psychiatrist, the students showed that they had long felt pressure from both the dormitory students and the administration to put an end

to the stealing. As the stealing increased in frequency and magnitude, the council members saw themselves as more and more ineffectual and became convinced that they had lost the respect, trust, and confidence of the students, the administration, and the housemother. They were also certain that unless effective action was taken by them, abandonment of student house government in favor of the more autocratic methods of the housemother would follow. In an effort to prevent this and to regain their previous stature, they tried to settle the problem by furnishing the house with a "culprit." It is pertinent to the aims of this paper to consider why the particular culprit chosen was chosen and to formulate a psychodynamic explanation of why this method was selected by the group.

Each individual has unconscious mechanisms of a primitive, magical nature for dealing with anticipated loss of esteem and love. Fenichel (2) has observed that some do this by the act of stealing. It is equally clear that others deal with this by promiscuous sexual activity, by grandiose lying, or by becoming admired for nonconformity or open rebellion. Most people, however, restrict these mechanisms to fantasy, but in every community there are those individuals who "act out" what, in most, remains fantasy. Such an "acting-out" student was the culprit picked by the house council for punishment.

By previously being suspected of lying, cheating, and promiscuous sexual activity, this girl made herself unpopular as a "bad" girl in the community. This behavior indicated that she had serious difficulties in gaining love, affection, and esteem from those around her. The members of the house council felt themselves to be in the same position as this girl and feared punishment for their ineffectualness. In order to deny these feelings of ineffec-

tualness and to forestall the punishment of further loss of respect and esteem, the group tried to furnish the house with a student they could punish.

This defensive maneuver is somewhat similar to that observed by Perry (8) who found that when a group of undergraduate students are confronted with an ethical problem, the earliest defense is the formulation of a moralistic impasse. It is also similar to Kotkov's (6) observation that, initially, members in a therapeutic group channel their own concerns onto a "scape-goat." It differs, however, from both of these in that feelings of resentment over loss of esteem and love were projected out of the group onto a girl who had "acted out" these feelings in the past and with whom, as a result, the girls could identify. By then punishing her in the way that they themselves feared punishment, the group was utilizing the defense of identification with the aggressor, described by Anna Freud (4). For the group work with the psychiatrist to be of benefit, the members of the group had to become aware of their own feelings of loss of esteem and then work through them with each other and with the psychiatrist. To begin this, the group was asked in the second meeting, "Why should you produce a culprit? Has this been a function of the house council?" The group was at first startled, then somewhat sheepish, but some members soon answered that "it was expected" of them.

In the first three meetings, the students saw the psychiatrist as a prototype of the administration, i.e., a stern, critical, distant father. But the psychiatrist was careful to refrain from criticism and accepted the group's criticisms with equanimity. As a result, they soon began to look upon him as an uncritical and neutral participant in the meetings, and individual members began to open up about their own

personal concerns. They discussed the questions of: how far to go with boys; how "free" to be in social behavior; and how independent it was safe to be. They had a great deal of difficulty in "drawing the line" as to what represented an excess in these areas, but were united in the belief that a student who went "too far" should come to the attention of the house council. Thus, for the first time, they showed a positive interest in assuming responsibility for dealing with student conduct. But the group was divided on how the student should be handled. A few members believed in close supervision of students, formation of definite rules of conduct, and the establishment of methods of punishment for infractions of these rules. The majority, on the other hand, supported the idea of a more flexible code, which would permit the student to use her discretion. If she seemed to be setting a bad example for the dormitory, the house council would discuss this with her and then take appropriate steps. Thus, two opposing groups had emerged, and the members were now concerned with the relations of members to each other.

Although the previous defensive hostility of the group had been worked through, group unity was precarious because of the presence of an opposing faction within the group. This faction, led by the vice-president, supported the more classically punitive methods similar to those urged by the housemother, whereas the majority of the group, led by the president, now advocated more liberal measures which represented the emphasis of the administration. It became obvious to the psychiatrist that competition for leadership between the president and vice-president had been present for some time and had prevented the formation of a basic group unity. This disruptive potential had become obscured

by the reaction to stealing, which had bound the group together in common defense. When the vice-president and her followers initiated in the house, then supported in the group, the action taken by the housemother with regard to the girl who was suspected of planning an unchaperoned week-end party, the majority of the group became openly critical of them. With less pressing external circumstances and with effective student leadership, such a split might have been worked through, but the psychiatrist felt that to support the vice-president and her followers meant further delay in the resolution of an acute problem within the dormitory, and he therefore refrained from intervention. The vice-president and her followers were unable to handle the criticism without help, and they withdrew from the meetings.

The group was then composed of members who would allow the formation of group cohesiveness based on common goals and ideals. But they still appeared indecisive about future plans. This was due to many factors, among which the following were of most importance: previous group ties had been disrupted; there was no effective student leadership; the group still feared student opposition and criticism; and there was no precedent to guide them in making plans.

In short, the members of the group seemed to be at another impasse from which they could either continue to progress or from which they could regress back into defensive hostility. They chose to progress and broke the impasse spontaneously by agreeing to meet with the students in small groups to discuss future plans. In addition, they asked the psychiatrist to help them behave toward the students as he had behaved toward them. This behavior can be clearly recognized as the defense of identification. This coin-

cides with the original observation of Freud (5) who noted in *Group Psychology and the Analysis of the Ego* that if previous libidinal ties of a group are broken, the group substitutes identification with the leader as a principal means of maintaining positive ties with other members of the group. Identification with a strong adult is one of the principal and more healthy defenses of adolescence, and, in this instance, replaced the more primitive defenses mentioned previously. The psychiatrist, therefore, supported this and directly intervened with suggestions of how the students could conduct the meetings and obtain results similar to his. This identification with the psychiatrist then allowed the council members to see the students and administration as less critical, and they were free to begin relating to the dormitory students as student leaders. The psychiatrist refrained, however, from any intervention in the plans for the actual mechanics of government, as this would have delayed the students in taking full responsibility for the management of dormitory affairs. As the students became more interested in their own plans and as student leaders appeared, interest in the meetings with the psychiatrist waned and were soon stopped by mutual consent.

When the meetings ended, the group had made significant progress in the dormitory. The dormitory students were more aware of the need for an active, autonomous dormitory government and showed more interest in this. Communication between the council members and the dormitory students, the administration, and the housemother had been vastly improved, and permanent arrangements to continue this had been adopted. A more flexible and workable constitution was being composed, and, as a result, the importance of the dormitory council in relation to the campus

student council had been augmented. Less progress, however, was made in relation to the group itself. Defensiveness and suspicion between the two cliques remained unsettled. It must be remembered that identification is helpful as an individual defense, but when used by a group, it still only provides a defensive basis for group unity, and in no way is it comparable in effectiveness to the development of mature member-to-member insight. Although the group was now able to work together in the presence of the leader, intragroup difficulties remained prominent at the open meetings, to which the dormitory students were invited. The dormitory students became aware of this and reacted by electing an entirely new council in the spring election. The new council was composed of girls who would continue to work for more student responsibility in managing dormitory affairs but who would proceed with this in a more relaxed and comfortable manner. The future president, in particular, was considered a girl of great ability. The dormitory was much less tense toward the end of the year, and the exodus of a psychotic freshman who was guilty of stealing caused little comment.

SUMMARY

In closing, this case report indicates that one of the more valuable contributions a psychiatrist practicing in the college community can make is to furnish help, when indicated, to student government groups

whose goals have become obscured. Unfortunately, the indications for psychotherapeutic intervention in a preformed, functional group are not always clear, but, if the solutions of student government appear to be consistently moralistic, inflexible, and emotionally overdetermined, evaluation by a therapist experienced in the application of dynamic group concepts can be valuable in a milieu where such an approach is not obstructed by faculty resistance.

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Book Reviews

THE NEGRO PERSONALITY

By Bertram P. Karon

New York, Springer Publishing Co., Inc., 1958, 184 pp.

This book represents a very good effort at describing and formulating what the author has chosen to refer to as "The Negro Personality." Rather, it might be called "The Hurdles of the Negro in American Culture."

It starts out rightly enough in a story form, but this style is soon departed from, with no reason for this sudden change. In the arrangement of the chapters in the book, it would have been more rational to place Chapter III before Chapter IX. It would then show, as a result of the presenting data, how this material affects the Negro psychology and thus produces certain personality characteristics. There is a tendency to repeat some of the material, as seen in Chapters II and III. Statistical data would have been more effective than mere repetition of statements of the sanctions, class structure on which caste is built, political disfranchisement, poor education training, a denial of educational opportunities, and all the abuses that the Negroes are heir to in this culture.

But a closer analysis and evaluation is also imperative. Many statements are only partially true, and many could be applied to any minority, while others could be applied more to the Negro than to any other group.

Examples of this may be seen in the following:

1. "In United States, Negroes are allowed to marry only Negroes." Rather, it should be said that "Negroes are not allowed to marry whites in many states."

2. "The Negro parents are often so overworked that they have little time to show affection for their children." This is almost a universal pattern in the post World War II era in the United States. The rich also hire governesses to take care of their children, and there, too, the same problem of affection exists.

This data is however exceedingly well-documented, probably as well-presented as by Gunnar Myrdal. An important factor in this whole episode—namely, the sexual factor—is given only minimal consideration. Scientific data has proved that very minimal or insignificant crossing between the Negro male and white female has resulted through the years, while the converse is the regular pattern—hence, the variety of color in the Negro race. The psychological implication of this factor has too often been overlooked.

The Rorschach interpretation of the Negro as given by Goldfarb is a myth. The American Indian, in offering physical resistance, was practically exterminated by the whites. The Negro had to find a different type of resistance in order to continue to multiply and grow in spite of every sadistic effort to destroy him in some areas. If his description be true of the sufferer, it would be equally interesting to know what the Rorschach would be of those who imposed the suffering.

Finally, the result of the tests used in this study are of doubtful value and, indeed, very hard to gauge and, thus, inconclusive.

The attempt of most writers to discuss the Negro and, thus, his personality make-up has so far not been very successful, as all start from slavery. To understand the Negro, it is necessary to know

something of the history of the Gold Coast area and Nigeria from which the Negroes were brought. A Toussaint, a King Christophe, a Sonni Ali-Kolen, or an Askia the Great do not come from a noncivilized group. It is necessary to see not 300 years of slavery but the many hundred years before this when these areas boasted of the Mellestine and Songhay empires, and many smaller ones, and the effects of Moham-medan culture and slave practices on these areas. It is noted by historians that this area kept pace with Europe up to the seventeenth and part of the eighteenth centuries until gunpowder overcame armies, with camels and elephants in the attack.

Lady Lugard, in *A Tropical Dependency*, wrote of the whites in the nineteenth century in Africa: "... we generally see them [the Negroes] as crafty and treacherous people, but it may well be said the Europeans have not dealt with them honestly, as become Christians . . . they have stolen the abundance of the people from time to time."

When a group has been skinned, fleeced, and flung down—either in his homeland or as a transported slave—regardless of race, what sort of personality would he evolve from such an exposure? What does it also do to the ones who impose this form of life? How does the Negro move forward in spite of this? How old is the Negro race so that it is able to handle this role assigned to it at present by history?

The point of view as expressed by Oversey and Kardinier is as wise as it is germane: "It would be a mistake to think of a group like the American Negro as having, as a result of the caste sanctions, a single 'basic' personality."

The book, if it does no other good, helps to keep before the public eye the sickness in this society and of the hurdles the Negroes are forced to overcome in order to

survive.—E. Y. WILLIAMS, M.D., Howard University, Washington, D. C.

DIFFERENTIAL TREATMENT AND PROGNOSIS IN SCHIZOPHRENIA

By Robert R. Wirt and Werner Simon

Springfield, Ill., Charles C Thomas, 1959, 198 pp.

The carefully performed task of Wirt and Simon and their collaborators is reviewed in their book, *Differential Treatment and Prognosis in Schizophrenia*. A multidiscipline approach was used, including many methods of psychiatric, psychological, and social work investigation, as well as several methods of statistical analysis. A random allocation of 80 acute male schizophrenic patients never before treated was made into 4 groups of 20 each: (1) Chlorpromazine, (2) Resperine, (3) Hospital Routine controls, and (4) Clinical Judgment group receiving what ever treatment or combinations of treatment were indicated by best psychiatric judgment.

At the end of 30 days, the Psychiatric Improvement Scale revealed that the Clinical Judgment and Chlorpromazine groups were significantly improved over the Resperine and Hospital Routine groups. The Chlorpromazine and Clinical Judgment groups were not reliably different from each other, and the Resperine and Hospital Research groups were not significantly different from each other either. After the 30-day evaluation, all 80 patients were given the same varieties of psychiatric treatments until discharge from the hospital. At that time, according to the Improvement Rating Scale, the Clinical Judgment group showed a highly significant improvement, while the routine administration of tranquilizing drugs to schizophrenic patients added little value beyond mere hospitalization. But chlorpromazine

was most valuable as an adjunctive aid, while the opposite was found to be the case with resperine. A year after discharge, the follow-up revealed the Clinical Judgment still to be the most effective beginning approach to treatment, with Chlorpromazine next. Then came Hospital Routine, and, finally, the Resperine group. The record of the last was inferior to that which had no treatment beyond hospitalization for the first 30 days.

The consensus of many observers using drugs in the therapeutic milieu of a therapeutically oriented hospital reveals that both chlorpromazine and resperine are of value in the management of schizophrenia, even in the absence of an eclectic scope of the other available therapies. It is true that chlorpromazine might have been expected to be more effective within a 30-day period because resperine is usually more slowly acting. But it is difficult to understand how resperine can reduce the therapeutic changes of a patient simply because it was administered for 30 days. The reviewer does not have a satisfactory explanation for the discrepancies, and especially because he was impressed by the careful analysis which was manifestly honest, yet the attitude of the observers towards their patients and the rapport consequently developed between the observers and their patients might be considered. A choice between two equivalent therapeutic procedures would have afforded less opportunity for attitudinal differences than that presented by pitting the best clinical judgment of the observers against choices rendered necessary because of experimental design. It is conceivable, too, that in the opinion of the staff, resperine was not highly regarded, even before the study began.

Perhaps the Resperine group was heavily loaded with patients refractory to any kind

of therapy. The small number of 20 does not offer much safety against such pitfalls of randomization. It should be pointed out that there is a discrepancy in the evaluations made, at the end of 30 days, between the results of the Psychiatric Improvement Scale, mentioned above, with those of the Behavior Rating Scale. The latter revealed that the Resperine group showed a reliable degree of improvement in behavioral symptomatology while the Hospital Routine group did not show a meaningful change.—HAROLD E. HIMWICH, M.D., Galesburg State Research Hospital, Galesburg, Ill.

COLLECTED PAPERS: THROUGH PAEDIATRICS TO PSYCHO- ANALYSIS

By D. W. Winnicott, M.D.

New York, Basic Books, Inc., 1958, 350 pp.

This is not a definitive text, but rather a collection of papers published over a period of years in the life of an analyst who started out as a pediatrician. The title immediately suggests usefulness to the pediatrician, but the message is really offered to practicing analysts. The pediatrician will find little encouragement, in terms of being able to use Dr. Winnicott's fundamentally sound psychoanalytic messages. In the last chapter, "Pediatrics and Childhood Neurosis," delivered at the Eighth International Congress of Pediatrics in July, 1956, Dr. Winnicott frankly stresses the relative necessity of personal analysis if the pediatrician intends to do psychotherapy. From the strictly psychiatric viewpoint, this is a reasonable idea, but the vast majority of pediatricians are necessarily engaged in their own levels of psychotherapy, although it is true that the pediatrician who has been analyzed and

is, therefore, relatively free of his own infantile predispositions, will do better with parents and children, many with underlying psychotherapeutic "talent" will find it difficult to understand Dr. Winnicott's messages. They will learn that they can indeed modify the child's environment through changing attitudes in parents, or substitute parents, and through brief vacations and additional contacts and facilities. Direct help by psychotherapy must be left to the psychoanalytically trained psychiatrist. This is well explained in the book, when Dr. Winnicott comments that "disliking it [psychoanalysis] is no argument against it . . . personal psychotherapy of children and adults" should be done by trained analysts. Nevertheless, intuition, empathy, and "goodness" in the average pediatrician are perhaps given less weight than is deserved because they do not equate psychotherapy in the classical sense.

There is an excellent approach to the fundamental family conflict arising out of the classical oedipal triangle. Pediatricians can indeed learn why this is the basis for intrapsychic growth, even though there will be large gaps in the explanations given by Dr. Winnicott. These gaps are hardly noticeable, of course, to the practicing child psychiatrist or analyst. The explanation of symptoms as "needs" is very comfortably and clearly given. There is a fascinating approach to the meaning and treatment of symptoms. The symptom is called "necessary," and relief of it by prescription may intensify the disease process. Thus, enuresis is a "need" in an immature or conflicted child and should be understood and allowed to clear. The child should be treated anaclitically. There is a hint, too, in the explanation of symptoms as standing for an unacceptable need: e.g., the eyes may "take in and excrete" in an

hallucinatory experience. Dr. Winnicott shows how symptoms which are "tolerated" will permit the illness to reach a "natural end." In further emphasis on the importance of good or "good enough" mothering, stealing and destructiveness are clearly shown to derive from "insufficient" mothering. In convincing detail, the point is made that the earliest anxiety of the infant relates to being insecurely held. Symptoms arise in the need for the mother who has not been sufficiently available. Thus, thumb sucking is for consolation rather than for pure pleasure. An interesting concept is set up to the effect that the mother hates the child first and that the child learns hate from her. She hates out of her prematernal residuals and particularly in reaction to the anxiety which pervades the pregnancy and the early period of maternity.

There is a noticeable lack of references to American child analysis. A good deal of importance is attached to Phyllis Greenacre's writings, with some mention of Kanner and Bender. The English literature is more extensively quoted, and Melanie Klein is given major credit for Dr. Winnicott's philosophy. His practical approach to problems of unconscious nature is commendable and convincing. He is able, for example, to approach children in their home environment under conditions which are extremely unfavorable, in terms of poor chances for sustained therapy. In such instances, he cuts through the understandable need for prolonged and intensive psychoanalysis and is able to effect startling results, as through one or two visits to a child in his home or in a hospital. He is a man of courage and clarity and makes no attempt to apologize for viewpoints which are essentially his own, yet not in keeping with classical textbook concepts.

This offers an excellent source of reference to child psychiatrists in private practice and in work with delinquents.—OSCAR B. MARKEY, M.D., Cleveland, Ohio.

PRINCIPLES OF ADMINISTRATION APPLIED TO NURSING SERVICE

By H. A. Goddard

New York, Columbia University Press, 1958, 106 pp.

This monograph has sections on: 1) the principles of administration, 2) the application of the principles, 3) the techniques of administration, and 4) a philosophy of administration. It has, also, seven annexes on: 1) the ward nursing plan, 2) the public health nursing plan, 3) sample job description form, 4) sample job qualification questionnaire, 5) sample job specification, 6) sample assessment scale for nursing personnel, 7) sample graphic assessment scale for nursing personnel, and a select annotated bibliography.

The list illustrates the breadth of material covered and the specific aides provided for the inexperienced nurse administrator who desires to improve her performance but cannot secure formal education and training for it. No doubt such an administrator would get much help from a thorough study of the book and an application of its suggestions.

The author points out the need for further study. The annotated bibliography is helpful in this regard.

To an experienced administrator the monograph is also interesting because it presents quite comprehensively, yet in clear and brief form, current knowledge for opinions about administration. Some points of special interest are: 1) the emphasis on the close interrelationship between policy development and administration and, hence, the necessity for active

participation of those concerned in administration in the policy-forming stages of a program (p. 12); 2) the importance of direct contact among all people engaged in a task, without necessarily having to go through the formal chain of authority (p. 17); 3) the importance of using examples given in the book as illustrations of how principles may be applied and not "as patterns to be meticulously copied" (p. 22); 4) the importance of good supervision both to the patient and the nurse (p. 36).

The definition used for "*staff relations*" is "those which arise when an individual is acting as the representative of a superior." The term "functional" is used in place of the term "staff" as it applies to the specialist who assists the line officer but does not exercise line authority (p. 20). If this distinction could be accepted more widely, it would do much to clear up confusion over the word "staff" as used in administration.

Flexibility in an administrative plan and in its execution is mentioned in several places. However, this reviewer questions the possibility of flexible administration when it is based on the philosophy as outlined in the section so entitled. For example, the emphasis on investigation—throughout the booklet—so that policy decisions can be based on fact and not opinion is commendable and of unquestionable value in sound administration. But the statement of philosophy states that it is important "to base *all* decisions on verifiable facts (p. 84)." How, in dealing with human beings, can one always be sure of what is a fact? How can one ever verify *all* facts? How, in a pioneering situation, which still exists in developing health programs in so many parts of the world, can we always wait until all the facts are in to start a program? How can an administrator meet an emergency in a flexible way

and yet insist that *all* facts be *verified* before action is taken? Yet the last sentence in the section on philosophy reads: "Finally, and perhaps most importantly, administration must be *completely* flexible, to meet the changing needs of the situation" (p. 85).

(The italics are this reviewer's.)

The monograph is well-organized and clearly printed. Numbering the sections or chapters as well as separating them by a title would have helped in using the book as a reference and in discussing it.

Taken as a whole, however, the monograph should be of wide interest and usefulness in universities providing education in nursing administration, in institutes and other meetings, and as a tool for those already on the job.—ANNA FILLMORE, Visiting Nurse Service of New York, New York, N. Y.

THE PSYCHOANALYTIC STUDY OF THE CHILD, VOL. 13

Edited by Ruth S. Eissler *et al.*

New York, International Universities Press, 1958, 573 pp.

Because of the large number of articles in this volume, my review will have to be limited to those articles which apply more closely to work with children. The articles, in general, are of a high caliber and must be read thoroughly to appreciate their value.

The first several papers are dedicated to the memory of Ernst Kris, who was one of the founders of "The Psychoanalytic Study of the Child" and made such important contributions to psychoanalytic research—especially involving ego development and functions. Phyllis Greenacre's paper on "The Family Romance of the Artist," the paper by Loomie, Rosen and Stein on "The Gifted Adolescent Project,"

and the paper by Ritvo and Solnitz on "The Influences of Early Mother-Child Interaction of Identification Processes" were all stimulated by Ernst Kris.

Anna Freud's article "Child Observation and Prediction of Development" is a memorial lecture in honor of Ernst Kris. She credits him with instituting studies on direct observation of children's behavior by child analysts, to supplement analytic studies. She refers to the difficulty of making predictions of childhood behavior because of the labile, transitory nature of the displacements of instinctual energy in young children. She is pessimistic about the possibility of making predictions of how a child will react to traumatic situations since this depends to such an extent on the child's make-up, early experiences, and relationship to his parents.

Heinz Hartmann's paper "Comments on the Scientific Aspects of Psychoanalysis" is a scholarly presentation of a controversial subject. He makes a plea for continued attempts to apply, as much as possible, research methods that may help to establish the validity of psychoanalytic theory.

Kurt Eissler, in his paper "Techniques in the Treatment of Adolescents," attributes the difficulty of working with delinquent adolescents to their lack of motivation for therapy. This is a result of a structural defect in the ego and super-ego. He does not believe we have enough data upon which to decide the wisdom of complete analysis of youngsters during adolescence. He rests his own decision on the capacity of the adolescent to accept such therapy without being thrown into deeper conflict. He believes that classical analysis can undo the damage of inhibition or neurotic symptoms that have resulted from too much restraint against the instincts. He feels also that it can help to close the gaps in superego lacunae of the

delinquent and can instigate a conflict between the ego and perverted sexual impulses, with the result that heterosexuality is encouraged.

He describes two phases in the treatment of schizophrenic adolescents. In the acute phase, when the world is a hostile, friendless place, the adolescent can be won back by an attitude of trust, warmth, and the absence of aggressive efforts at therapy. In the later stages, he can respond more or less like other patients in therapy. Special emphasis must be placed on locating the external sources of stress and danger. He cautions against analyzing resistances of psychotic adolescents.

Anna Freud also has a paper on "Adolescence." She feels, in general, that adolescents do not do well in classical analysis because of their preference for acting out, as opposed to verbalization, and because they have too little libido available for transfer to the analyst. The adolescent, in his struggle to emancipate from parental ties, seeks libidinal objects as different as possible from his parents. The analyst is too likely to stir up his relationship with his own parents. In general, adolescence is a period of interruption of peaceful growth and of disharmony within the psychic structure. The defenses of the ego against the id represent healthy efforts to restore harmony. His vagaries, inconsistencies, loves, and hates are a part of his normal development. He is looking for the emergence of adult personality structure, and it is often more important to work with parents to help them live with the adolescent.

Leo Spiegel in "Comments on the Psychology of Adolescence" thinks of adolescence as the period for the assimilation of the genital sexual drives into the self. During early adolescence, homosexuality remains strong and later loses ground to

heterosexuality. He feels that acting out by the adolescent is one of the major devices in the attempt to find new ideals.

Elizabeth Geleerd's paper, "Borderline States in Childhood and Adolescence," emphasizes the problem of the early relationship between the infant and mother. In satisfactory ego development, the young infant, she believes, becomes aware that relief from tension comes from the outside world. This is the normal, confident expectation of rescue when relief is not forthcoming from the mother. The seriously disturbed child may be unable to tolerate denial when away from the mother. He is unable to maintain the mother as an object when she is not present.

David Beres has an interesting article on "Vicissitudes of Superego Functions and Superego Precursors in Childhood," which helps to clarify a good deal of unclear thinking about the relationship between ego and superego development. He believes there is no way of knowing how far ego functions must progress before the superego can be structured, and after the superego develops, it may be impossible to tell whether the reaction comes from the ego or superego. Early remorse and "morality" may come from identification with the parents before the superego develops. It is his opinion that the so-called archaic, pregenital superego is more ego than superego.

According to Beres the sense of guilt is always a response to tension between ego and superego and is the hallmark of an internalized superego. He rejects the assumption that self-punishment is always a reaction from the superego and refers to the absence of guilt feelings, especially in children who may be self-destructive. He believes that the turning of aggression onto the self and early reaction formation are precursors of superego development rather

than reactions in the superego. He wisely recommends a good deal more research in the study of superego development.

René Spitz has a paper on "The Genesis of Superego Components" in which he emphasizes the fact that identification with the aggressor plays an important part in the development of the superego. In this way, the young child helps to change passive experiences into active ones.

Mary Bergen reports on "The Effect of Severe Trauma on a Four-Year-Old Girl" in which she discloses how unconscious fantasies determined the way this child, whom she analyzed, reacted to the trauma of witnessing her mother killed by the father. This is a theme that Anna Freud has emphasized for many years.

Vivian Jarvis discusses the problem of reading disability in her paper "Clinical Observations on the Visual Problem in Reading Disability." She emphasizes the role of the fear of blindness in several children she analyzed. This fear was based on castration anxiety resulting from incestuous conflict. This study was based on analytic treatment of youngsters with reading disability.

Phyllis Greenacre has a paper on "The Relation of the Imposter to the Artist." According to her, the career imposter has serious ego and superego defects which prevent the development of good object relationships. His early ties to his parents lack real warmth, and there is an absence of genuine identification. His Oedipal conflict is re-enacted in each act of imposture. The chief theme, however, is not the winning over of the mother in a libidinal way; it is the dethroning of the father and the taking over of his power.

The artist also fails to resolve his Oedipal conflict. He spreads his influence and libido over the world and remains frustrated in his relation to objects. This is

compensated by creativity, and he works feverishly to achieve what is denied him through real object relationships.

As usual, the high quality of the papers we have learned to expect from "The Psychoanalytic Study of the Child" is maintained in this number. I am sorry that several important papers had to be omitted because one could not do justice to them in a few words. This publication is highly recommended, as are all the previous publications of this Annual.—HYMAN S. LIPMAN, M.D., Amherst H. Wilder Child Guidance Clinic, St. Paul, Minn.

SIGMUND FREUD: COLLECTED PAPERS

Authorized translation under the supervision of Joan Riviere

New York, N. Y., Basic Books, Inc., 1959, five volumes (boxed)

This first American edition of Freud's *Collected Papers* is identical, except for the brown binding and the slightly smaller size, with the familiar large green volumes of the International Psychoanalytic Library, Hogarth Press. This edition has used the same plates so that pagination, as well as every word, is identical. The smaller format is more convenient, and the large print is a pleasure often wished for in other books worthy of careful concentrated study. These volumes are welcome since they still are so rich psychoanalytically, although the field has developed so well and has so far integrated with other disciplines that it is no longer true that "if it isn't in the *Collected Papers*, it isn't psychoanalysis." Unsystematized and exploratory though they are, they will be required source reading for years to come, both for their psychoanalytic content and for the contact they give the

reader with the fine mind and personality of the man who has so greatly influenced not only psychiatry but Western thought.—LEON J. SAUL, M.D., Media, Pa.

THE PROBLEM OF DELINQUENCY

By Sheldon Glueck

Boston, Houghton Mifflin Co., 1959, 1,183 pp.

Professor Glueck has performed a very valuable service by the publication of this excellent 1,200 page source book on juvenile delinquency. The work is characterized by the high caliber of scholarship and the admirable amount of industry which has characterized the author's publications ever since the appearance of his pioneer volume, *Mental Disorder and the Criminal Law*, 35 years ago.

The Problem of Delinquency is divided into four sections: "Incidence and Causation," "The Juvenile Court and the Law," "Treatment," and "Prevention of Delinquency." The included materials reflect the author's conviction that multiple forces and factors must be considered in any realistic approach to the delinquency problem. He draws heavily upon the important contributions that he and his gifted wife have made in their studies of juvenile delinquency during the past quarter of a century, with particular emphasis on their well-known prediction tables.

There are 186 sources of material, most of them journal papers, reprinted in entirety. Fifty court opinions dealing with the basic legal issues involved in proceedings against juveniles are reproduced. The footnotes and references at the ends of chapters furnish an invaluable and almost inexhaustible bibliography on all aspects of delinquency.

It is not possible to single out papers from a collection of such magnitude that starts with Lombroso, for special mention.

Among the authors, psychiatrists are well-represented.

The editor expresses the hope that this teaching instrument will assist in training prospective prosecutors, judges, probation and parole officers, clinicians, and social workers in the intricacies of the problem. To be sure, there is much that the members of each of these professions will find here. And, now that modern medicine is stressing increasingly the importance of the social environment, it is to be hoped that all departments of psychiatry will give this volume a place of prominence in recommended reading for medical students.—MANFRED S. GUTTMACHER, M.D., Baltimore, Md.

CHILDREN'S VIEWS OF THEMSELVES

By Ira J. Gordon

Washington, D. C., Association for Childhood Education, 1959, 36 pp.

In her foreword to Dr. Gordon's little book, Gladys Jenkins says that the author "has made the feelings of children about themselves come alive for us."

This is indeed what one experiences in going through the lively examples the author provides under such topics as the role of self-estimates in behavior; how self-concepts come about; how adults can estimate children's self-concepts; how adults can help.

First on the list in Dr. Gordon's book is Kay, an early maturing girl in the physical education class, who just "cain't do it;" then Tim, an energetic seven-year-old who sees himself as able to "lick the world;" John, a gangling early adolescent, who feels alone, rejected, out-of-step and out-of-place; Mary, who views the world in bright colors and sees most of her interpersonal relationships as rewarding.

The behavior of children, the author maintains, is greatly influenced by both their generalized and their specific notions about themselves. As to how these self-concepts come about, "perhaps the most important factor is the general climate of feeling which exists in the home." But school and peer influences are also significant, Dr. Gordon adds.

As to how adults can help, the author suggests: set realistic expectations; provide for productive and creative work; provide a variety of stimuli; trust children; and provide for immediate "feed-back,"—since the sooner the child receives evidence of the effectiveness of his response, the faster and better he will learn. As to "discipline," many difficult situations can be avoided, the author maintains, if the teacher asks himself whether or not a certain experience is really necessary for the child.—W. CARSON RYAN, PH.D., University of North Carolina, Chapel Hill, N. C.

THE CRIMINAL MIND

By Philip Q. Roche

New York, Farrar, Straus & Cudahy, 1958, 299 pp.

This study is an attempt to improve communication between criminal law and psychiatry by Philip Q. Roche, M.D., the fifth winner of the Isaac Ray Award of the American Psychiatric Association. In essence, Dr. Roche proposes that society permit the psychiatrist to stick to his last and restrict his testimony as an expert in trials involving the criminal responsibility of the defendant to facts pertinent to his specialty and be excused from expressing opinions involving value judgments concerning the defendant and his actions, which he does not feel the psychiatrist is any better qualified to make than any educated layman, and that such value judgments should be left to the jury after they

have been given all the available and pertinent facts, including the psychiatric facts.

The devil in this book is the M'Naghten rule and, to a lesser extent, the "product" rule of the recent Durham decision, which he states, "belongs to the same filum of invertebrate abstractions, as does M'Naghten, which can be put to a jury but not to a psychiatrist," although the general reaction to the Durham decision is that it permits the psychiatrist greater freedom than heretofore in giving the psychiatric facts to the jury. Since their inception in 1843, the M'Naghten rules have been a bone of contention between lawyers and psychiatrists in English-speaking countries. They are briefly known as the "right and wrong tests." Fortunately for the psychiatrists, the semantic hairsplitting concerning partial insanity and the nature of the delusions have gone by the board, but most of the states still adhere to that part of the M'Naghten rule which states that "in order to establish a defense on the ground of insanity, it must be clearly proved that at the time of the committing of the act the accused was laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong."

In 1954, Judge David L. Bazelon of the United States Court of Appeals for the District of Columbia in the case of Durham versus the United States held that, as an exclusive criterion of criminal responsibility, the right and wrong test is inadequate in that it does not take sufficient account of psychic realities and scientific knowledge and concluded that a broader test should be adopted; viz, "the accused is not criminally responsible if his unlawful act was the product of mental

disease or mental defect." Also of interest is the fact that the British Royal Commission on capital punishment in 1953 recommended abrogation of the M'Naghten rule leaving the jury to determine whether the accused was suffering from a disease of the mind or mental deficiency to such a degree that he ought not to be held responsible at the time of the commission of the crime. It would seem that there is a general movement in the direction, both by law and psychiatry, to consider mental illness as something for which the individual should be treated rather than be punished, and that a person should not be considered criminally responsible if suffering from a bona fide mental illness.

The crucial question, therefore, is what society will accept as mental illness of a sufficient degree to exculpate the individual accused or convicted of a crime. Of particular interest, then, is Dr. Roche's second chapter, entitled, "What is Mental Illness?" In the first place, he suggests an operational definition, quoting Bridgeman, that "the true meaning of a term is to be found by observing what a man *does* with it, not by what he *says* about it."

When does mental illness become insanity? It would seem, according to Dr. Roche, that "when socially maladaptive behavior reaches a point regarded by society as intolerable, the culture then provides expedients of alleviating the social tensions attending it, and that behavior so designated as mental illness merely becomes changed in name to insanity, which name carries with it a susceptibility to externally applied force which alters civil status."

He apparently feels that this does not change the fact of mental illness, observing that marriage changes a girl's name and alters her civil status; it does not change her. This is a questionable state-

ment, as the fact of marriage frequently changes a girl's previous behavior, so I wonder whether the chapter on "What is Mental Illness?" does not tend to confuse the issue and impair communication between the lawyer and the psychiatrist rather than clarify it. However, as this is a complex, multidetermined phenomenon, the author is to be congratulated for at least trying to clarify this matter. Society is apparently prepared to concede that a criminal cannot be a criminal if mentally ill at the time the criminal act occurred. Then, if there is such a thing as a criminal, he must be basically different from the mentally ill person. However, Dr. Roche says that criminals differ from mentally ill people only in the manner we choose to deal with them. Why, then, do we choose to deal with them differently? According to Dr. Roche, for theological reasons. This type of thinking would seem to me to unduly confuse the issue, as from a pragmatic point of view there are many criminals who by all medical tests are not mentally ill but other criminals who by accepted psychiatric procedures are undoubtedly suffering from mental illness. Society is beginning to recognize that it is this group that should be treated rather than punished.

The book is well worth reading by all those concerned with the problem of criminal responsibility. The case reports are both interesting and instructive in demonstrating the split between law and psychiatry. Much of the language in the book borders on the obscure, which is unfortunate because the intent is to improve not impair communication between the lawyer and the psychiatrist. Dr. Roche indicates from his formulation that the psychopath is as sick as the psychotic but begs the question of responsibility by insisting that the psychiatrist is not compe-

tent to judge responsibility, as this is a legal, moral judgment and not a medical matter. Be that as it may, the psychiatrist, as an educated layman, is expected by society to express value judgments based on his understanding of personality, and I am afraid he does not help the cause of justice if he refuses to participate. This is exemplified by the Ballem case. It is therefore not clear to me just what Dr. Roche recommends to improve our communications with lawyers, other than restricting the psychiatrist to purely medical testimony.

The experience at Bellevue indicates that, by and large, the court accepts the opinion of impartial psychiatric experts, and although we have to cope with the M'Naghten rule and its modification under the code of criminal procedure, very few, if any, psychotic criminals have come to trial or been punished if they have. The rule does not give much trouble to the pragmatically oriented psychiatrist provided the accused is psychotic. Dr. Roche does not suggest it, but an impartial court-appointed panel of psychiatrists would seem to be the best answer to the battle of the experts. The psychopath or character disorder is another matter, and it is doubtful if society is going to consider them exculpable for a long time to come, and it is also doubtful if the best interests of psychiatry will be served if unconscious determinants are stressed by the psychiatric expert to the detriment of common sense.

—LEWIS I. SHARP, M.D., New York, N. Y.

THE STUDENT AND MENTAL HEALTH: AN INTERNATIONAL VIEW

New York, World Federation for Mental Health, 1959, 495 pp.

This volume is the report of the first International Conference on Student Mental

Health, which brought together mental health workers primarily interested in college students. Regrettably, but necessarily, the conference had to be small, but fortunately this excellent report will give evidence to those who could not attend some idea of the broad spectrum and the high level of the meeting and some idea of the major problems discussed.

Farnsworth's opening paper entitled "Why Have a Conference" led into a report by student delegates from various countries on their views of mental health. Next, a representative from each of the countries gave a brief survey of the basic problems of student mental health in his native land. Erikson, by means of his excellent conference discussion on "Late Adolescence," seems to have keynoted the conference, for the various groups began their discussions by considering his work and his thesis on the problems of "Identity Crises." Leo Berman, Helen Ross, Margaret Mead, H. B. M. Murphy, and Ehrich Fromm also introduced conference discussions, the caliber of which are all of the high level expected of these well-known individuals. Dr. Berman's chapter on group work with educators is especially noteworthy, as he outlines the various advantages and pitfalls connected with it. Few of us realize the vast amount of dedicated work which Berman, Farnsworth, and others have done to convince administrators and faculty members of colleges of the advantages of mental health programs in their institutions. Helen Ross addressed herself to that ever-challenging problem: the role of the teacher and how much, if any, therapy should be asked of her. There is no doubt but that she speaks with authority, and one can readily agree with her conclusions.

It is not possible to comment at length upon all of these excellent presentations, much as one would like to do so. Here are

excellent insights by Erich Fromm, Margaret Mead, and numerous others less well-known but just as intense in their efforts—individuals who are blazing new trails in areas heretofore isolated. One can state without reservation, however, that the whole tenor of the work is excellent. The fact that Funkenstein and his colleagues were able to digest more than a million and a half words and put them into an informative, readable, interesting sequence is a major feat in itself.

The group discussions are of high level, whether concerned with married students or with those students who seem to their teachers to fit Browning's words: "Small finite clouds untroubled by a spark," (page 257.) There are discussions of relationships with faculty, the institution of programs in small colleges, the students who need help and reject it, etc. One notes with regret that those who are in the forefront of opposition to mental health programs are frequently the physicians and surgeons.

There is no doubt at all but that this was a fruitful conference and no doubt, either, that it is reported in superior fashion. It is probable that all meetings concerned with the mental health of college students for the next decade will have close reference to the work reported in this volume. It is to be highly recommended.—FRANCIS J. BRACELAND, M.D., The Institute of Living, Hartford, Conn.

EVOLUTION OF NERVOUS CONTROL FROM PRIMITIVE ORGANISMS TO MAN

Edited by Allan D. Bass

Washington, D. C., American Association for the Advancement of Science, 1959, 240 pp.

The title of this book implies an aspiration rather than fulfillment; one finds little

more than generalities concerning the evolution of nervous systems, and chief preoccupation with the behavior of the mammal. The preface hopefully outlines a most worthwhile project; the introductory chapter states its philosophical implications; and three following papers deal respectively with the chemical nature of embryonic organizers, with adaptations and differentiations of fundamental neural processes, and with the electrophysiology of the neurone. The next three papers deal with brain chemistry in the mammal and the reaction of the brain to chemical agents, paying only lip service to the evolutionary theme. These are followed by chapters on behavior after brain damage and a statement of psychoanalytic techniques and interpretations. The book does encompass a variety of approaches to the functioning of the nervous system, if not a review of its origins and development toward man. No discussion of one paper by the author of another is included, nor has any author significantly correlated his material with that of another, in what was originally delivered as a symposium.

Nothing said here need be taken as disparagement of the too-individual presentations at a conference on a common theme. The high points of the various papers for this reviewer are as follows, necessarily torn from their interpretative contexts and reluctantly omitting a personal evaluation of respective merits: The agents which determine development in the nervous system (Niu) are of the nature of nucleoproteins, the inductive specificity being controlled chiefly by the ribonucleic acid component. Presumably the RNA, given its specific configuration from patterning by the hereditary DNA of the nucleus, becomes further specific with respect to its combinations with proteins, and any one organism, containing a multitude of

genes, develops a corresponding number of species of nucleoproteins to direct its differentiation. Nerve conduction (Prosser) is presented as a special development of the biochemical polarization of cell membranes in general, further differentiated in various directions to form specific adaptive mechanisms. It is particularly noted that these adaptations of nervous properties are not necessarily to be arranged in a single evolutionary sequence, culminating in the mammalian brain. That is, of the various potentialities of nervous tissue, any one organism may develop to a high degree of efficiency one aspect of function, which may still be functional at a lower level of elaboration in a nominally higher animal.

With this theme as a guiding concept, this chapter on comparative physiology is the one most oriented toward the evolutionary viewpoint. Increase in number of cells, in their interconnections, and selective distribution of nerve cell potentialities to appropriate integrative and facilitatory mechanisms constitute the process of nervous system evolution. Grundfest (Evolution of Conduction) reviews again the primitive nerve cell's differentiation and discusses the functions of different parts of the neurone with respect to electrogenesis, putting final and greatest emphasis on chemical transducer action at synapses. He justifies his title chiefly by the inference that chemical transmission may have preceded all-or-none conduction, without consideration of the different connotations of evolution and of adaptation emphasized by Prosser.

There follows a discussion (Koelle) of the chemistry and pharmacology of neurohumeral agents, acting at synapses or otherwise; a study (Brady) of the effects of drugs, particularly certain tranquilizers, on behavior of mammals, in carefully designed experimental situations; and a more general essay on the chemistry of brain components (Page) and the effects of chemical agents on brain function. The last two papers leave the evolutionary field entirely, both dealing with aspects of nervous system activity in mammals. The first of these (Teuber) describes the results of psychometric tests on human subjects with localized brain lesions or ablations. The second (Mirsky) appears to accomplish a psychoanalysis of psychoanalysis, neither of which procedures is within the competence of this reviewer, but the chapter is no less intriguing on that account.

What is missing here, if the promise of the title were to be fulfilled, is a logical tracing of the chemical, physiological, and organizational behavior of successively higher nervous systems. One of the features of such an analysis should be the distinction noted by Prosser between the particular sequence of changes along, say, the primate limb of our family tree, and the adaption of various nervous systems along other branches to the specific environments they have invaded. Man may be the apical florescence on his family tree, but a lot of interesting and successful nervous systems adorn its lower branches, some of them showing better self-control than does our own.—GEORGE H. BISHOP, M.D., Washington University, St. Louis, Mo.

Notes and Comments

NAMH ESTABLISHES RESEARCH FOUNDATION

Embarking on a greatly expanded program of research in the field of mental illness, the National Association for Mental Health has set up a new foundation to conduct all association research activities.

The new foundation, known as the Research Foundation of the National Association for Mental Health, will allocate grants for projects and programs concerned with the causes, prevention, treatment and cure of the various mental illnesses. It will also provide fellowships for medical students interested in research on mental illness.

Dr. Harold Elley, Wilmington, Del., formerly chief of research of E. I. duPont de Nemours Company, is president of the new foundation. Its director is Dr. William Malamud, director of professional and research services of the NAMH and acting executive director of the association.

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TRAINING

Letchworth Village, a state-supported institution for mental defectives, administered by the Department of Mental Hygiene of the State of New York, has announced its 1960-61 graduate course in mental retardation. The institution is located at Thiells, N. Y., 30 miles north of New York City.

Four institutes of three weeks each will be given during the current academic year. The dates are: September 19-October 7, 1960; October 17-November 4, 1960; March 13-March 31, 1961; April 10-April 28, 1961. The course is intended to supplement the training of the psychiatric and pediatric resident and to broaden the perspective of medical staffs of institutions. Lecture seminars, lecture demonstrations and individ-

ual evaluation of assigned cases, supported by case seminars, constitute the basic teaching modalities of each institute.

There are no tuition fees for the course, but residency centers and institutions are expected to be responsible for salaries of the staff members while they are in attendance. Funds are provided by the National Institute of Mental Health to cover the cost (\$45) of room and board and the cost of transportation for one round trip between the home station and Letchworth Village at the minimum plane, railroad or bus tariff.

Application forms and further information may be secured by addressing:

The Program Director, Graduate Training Division, Letchworth Village, Thiells, Rockland County, New York.

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Forty college students from several Western states recently completed a 10-week pilot mental health summer work and study program designed to interest young people in the mental health disciplines. The seven Colorado state institutions participating in the University of Colorado program gave the students actual work experience in an institutional setting. Co-sponsoring the program were the state of Colorado, the Western Interstate Commission for Higher Education and the state and local mental health affiliates.

* * *

The new mental health careers program being conducted by the National Association for Mental Health got underway last month with the opening of the nation's schools. The NAMH has prepared a guide for its local mental health affiliates outlining suggested procedures to follow in working with

school and youth groups on community careers programs.

The association is also preparing kits of materials for school personnel: principals, counselors, health educators. These materials will include suggestions on ways educators can excite students' imaginations about careers in mental health.

The NAMH has also sent out letters to all school counselors who are members of the American Personnel and Guidance Association to acquaint them with the mental health manpower shortage and to announce that they will soon be receiving information material on the new careers program.

* * *

CARE AND TREATMENT

The Philippines has greatly improved its mental health services, with the assistance of the World Health Organization. The National Mental Health Hospital has been modernized and is rapidly undergoing further improvements; mental health workers are being trained; mental health clinics are being set up in the provinces; and the creation of a mental health division in the Department of Health is going ahead.

The Philippine Mental Health Association, founded 10 years ago, has today a membership of over 32,000. The Association runs guidance clinics in Manila and in two provincial cities. Since the future mental health of a country depends largely on finding and treating mental disorders in children as early as possible, the association has started a mobile mental health clinic which serves the schools in Manila.

* * *

More persons in England and Wales are entering mental hospitals, but the average length of their stay has decreased, according to a supplement on mental health to the

Registrar-General's Statistical Review of England and Wales for the Years 1954-1956.

In 1956, 83,994 people were admitted to mental hospitals in England and Wales; 56 per cent of them were on first admission. These figures showed an increase over 1951 of 23 per cent for men and 22 per cent for women. The number of people going in for a second or subsequent stay had also increased; by 75 per cent for men and 79 per cent for women. By 1956 the proportion of voluntary patients among first admissions had reached 78 per cent.

Yet the number of patients in hospitals at the end of the year went down from a maximum of 148,080 in 1954 to 145,593 in 1956. These figures include a decrease of 5,312 among patients aged 55 or less but an increase of 2,825 among patients over that age.

First admissions for alcoholism rose from 394 in 1952 to 458 in 1956; readmissions rose from 274 to 574. For psychoses of all kinds, most admissions were of persons in urban areas with a population of less than 100,000. For schizophrenia the highest rates of admissions were most frequent among people in urban areas with populations of less than 50,000. Admission rates and readmission rates were at their lowest among the managerial occupations, highest among unskilled workers.

* * *

STUDIES AND REPORTS

Results of the first five years in the "new era" of mental hospital care were announced by Dr. Paul H. Hoch, New York State Commissioner of Mental Hygiene, at the annual meeting of the New York Association for Mental Health.

Quoting a report to Governor Nelson A. Rockefeller on the period 1955-1960, Dr.

Hoch pointed to a reduction of 4,949 in the total number of New York State mental hospital patients. On March 31, 1960, the report indicated, there were 88,610 patients in the department's 18 mental hospitals.

"Throughout the history of the mental hospitals, there was a constant increase in resident population," Dr. Hoch observed, "until 1955 when the rising trend was suddenly and dramatically reversed. The peak was reached in June, 1955, when we had 98,559 patients. In recent years the increase had averaged 2,000 annually. If the rising trend had continued, we would have had an increase of 10,000 patients since 1955. Instead we have had a reduction each year so that our patient census is now some 5,000 less than it was in 1955."

"It is significant," Dr. Hoch continued, "that this decrease has occurred during a period of rapidly rising admissions (21,500 in 1955; 26,500 in 1960). This means that in reducing our population we were absorbing a substantially larger number of new patients each year. We were able to do this because of a 40 per cent increase in the number of patients released."

The higher release rate, he said, is a direct result of vast improvements in the therapeutic program including large scale use of the tranquilizing drugs, intensive treatment for newly admitted patients, the development of milieu therapy, and the establishment of the open ward policy.

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A county-by-county report on annual wages lost due to the hospitalization of persons at the Wyoming State Hospital has been issued by Mr. Robert Kelso, a hospital staff member. Mr. Kelso estimates that the annual lost earnings of potentially employable male patients would total \$672,612,000. The annual lost earnings of female patients he estimates at \$106,599,000.

A workshop on the voluntary insurance programs now being offered in Ohio, as they relate to the benefits for psychiatric care, was held last month. The Mental Health Federation of Ohio in co-operation with the state Department of Mental Hygiene and Correction brought together experts in the fields of psychiatry, hospitalization of the mentally ill, and insurance to examine the Ohio programs.

* * *

Seventy-three per cent of all the Blue Cross Hospital Service Plans in the U. S. and Canada carry a minimum 21-day hospitalization provision for mental and nervous disorders. This was disclosed in Fact Sheet No. 12 issued by the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health.

Of the 85 Blue Cross plans, 62 carry this minimum provision, the report states, pointing out that this represents a sharp increase during the past five years. In 1955, only 39 plans included this coverage. During this same period, too, the number of plans excluding mental and nervous disorders entirely has decreased from 21 to 12.

However, the report notes that "only seven Blue Cross plans in the United States and Canada offer their subscribers a certificate or certificates covering the mental illnesses to the extent that most physical illnesses are covered."

In many of the plans' provisions, benefits offered are provided only on the "contracting hospitals" or "general hospitals" thereby excluding the subscriber treated in private (or public) mental hospitals.

* * *

Normal persons seem to have a built-in capacity for solving many of the problems associated with growing up which in time

enable them to work out their own ways of adjusting to the workaday world. This is a conclusion reached by a team of University of Minnesota child psychologists who studied the behavior and adjustment patterns of students and young adults in Nobles county between 1950 and 1957. The study of the entire school-age population in the county, between ages 9 and 17 years, was headed by two former directors of the university's Institute of Child Development and Welfare, Dr. John E. Anderson and Dr. Dale B. Harris. A summary of the results of the survey is found in a monograph entitled *A Survey of Children's Adjustment Over Time* published in 1959 by the Institute of Child Development and Welfare, University of Minnesota, Minneapolis 14. A full report of the findings will be published by the institute at a later date. Copies of the summary are available upon request to the institute.

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Parents who institutionalize their retarded child do not necessarily love him less or treat him with less affection than those who are able to keep him at home. In fact, parents' attitudes toward mental retardation and their retarded child appear to be only a minor factor in the decision to institutionalize.

This was one of the significant findings of a two-year study of factors influencing the institutionalization of the mentally retarded in New York City released by the New York State Commissioner of Mental Hygiene, Dr. Paul H. Hoch. It was noted during the study that the proportion of parents who showed considerable attachment to their retarded child and displayed warmth, love and affection was equally high among parents who kept their child at home and those who were forced to institutionalize because of home problems.

Conducted by Dr. Gerhart Saenger, director of the Research Center of New York University's Graduate School of Public Administration and Social Service, the study was made under the auspices of the New York State Interdepartmental Health Resources Board. It was designed "to cast further light on the many faceted social-medical problem of retardation, with particular emphasis on clarifying the factors related to institutionalization and the complex interaction between these factors."

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LEGISLATION

Secretary of Health, Education and Welfare Arthur S. Flemming has sent to the Congress a draft bill to strengthen and augment Federal and Federal-State programs directed toward improvement of the Nation's health resources in the critical fields of professional health manpower and of facilities for patient care.

The proposed legislation would: (1) revise, consolidate and improve the Hospital and Medical Facilities Construction Grant Program now authorized by Title VI of the Public Health Service Act; (2) amend Title VII of the Act to authorize a 5-year program of construction grants for teaching facilities which would expand the training capacity of schools of medicine, dentistry, osteopathy and public health; (3) authorize a five-year program of project grants to schools of public health and to those schools of nursing and engineering which provide post-baccalaureate training of public health nurses and engineers, for the purpose of strengthening or expanding graduate public health training in such schools; and (4) authorize a five-year program of Federal credit assistance in the construction of group practice facilities, with the Federal

Government guaranteeing payment of the debt service on obligations issued to finance such construction.

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The U. S. Senate has voted to appropriate \$110,800,000 for the 1961 budget of the National Institute of Mental Health. This is \$43,237,000 more than the total proposed by the administration, \$30,937,000 over the House allowance and \$42,710,000 more than the 1960 budget. The measure was scheduled for final Congressional action as this issue of *Mental Hygiene* went to press.

The Senate Committee Report on Department of Health, Education and Welfare appropriations includes recommendations for expansion of NIMH research, research fellowship, training and clinic programs.

The Committee recommended \$42,150,000 for the research grant program of the Institute, an increase of \$11,460,000 over the House allowance and \$15,460,000 over the budget estimate. Of this recommended increase, the Committee directed that \$1 million be allocated to research on aging. The Committee also recommended an additional \$1.5 million over the budget estimate for the Psychopharmacology Service Center for "research on the mode of action and clinical effectiveness of new psychiatric drugs."

Further, the Senate provided \$5,139,000 for construction of a Mental Health Neurology Research Facility; the balance of \$7 million is to be provided by the Neurology Institute.

Also recommended is the sum of \$2 million for the creation of "regional clinical research units designed to intensify the accumulation of research knowledge and to make certain that the latest research discoveries are promptly evaluated and used in various parts of the country." The Senate Committee went along with the House

recommendation that \$1 million be specifically earmarked for research, training and demonstration projects in the field of juvenile delinquency.

To help "alleviate the severe shortage of psychiatric research workers," the Committee recommended an additional \$2,094,000 for 1961 for the research fellowship program. The budget estimate proposed to freeze this program at the 1960 level of \$1,996,000. The Committee also recommended the sum of \$1 million for the support of full-time research positions designed to "bolster the inadequate research training resources of our medical schools."

The Committee recommended \$45 million for the training programs of the NIMH during fiscal 1961. The budget estimate had proposed a cut of approximately \$4 million for training funds for the coming year. The House rejected this cut by adding \$6,500,000 to the training program. Most of this increase, however, was earmarked toward financing the "paying-out" of the graduate psychiatric training grants a year in advance. The Senate Committee recommended that \$12,150,000 be allocated to provide for the forward financing of graduate training grants in psychiatry and related areas. The Committee also recommended \$5,300,000 for the general practitioner training program, an increase of \$3 million over the budget estimate. A total of \$1 million over last year's \$300,000 was recommended for a training program of psychopharmacologists.

The Committee recommended that \$6,500,000 be allocated for the matching grant-in-aid program for the support of mental hygiene clinics and other community mental health services at the state and local level. This increase of \$1,500,000 over the budget estimate is needed, the Committee report stated, "to bolster the basic clinic grants to the poorer states."

New Georgia mental health legislation effective last July 1, has been termed a "bill of rights for the mentally ill." The new laws, passed in January by the state General Assembly, mean that mental patients in Floyd County will no longer be confined in jail cells while awaiting a sanity hearing or transportation to the state hospital.

Two other major points are included in the new legislation: (1) Because mental patients will retain their citizenship rights, they can communicate by sealed mail, receive visitors and exercise all civil rights including the right to vote; (2) The law provides that a person subjected to a lunacy hearing must be served with a copy of the petition before he can be hospitalized; he must also be represented at the hearing either by an attorney or a guardian.

* * *

Senator Pat McNamara of Michigan has introduced a bill (S. 3807) containing a 10-point Declaration of Objectives for Senior Americans and establishing a U. S. Office of Aging to deal with the full ranges of problems affecting America's 16 million senior citizens.

Stressing the need for an Office of Aging, Senator McNamara said: "To date there has been no way to deal systematically with the complex and interrelated problems of the aged. Lack of co-ordination has led to wasteful duplication and overlapping of effort as well as neglect of problem areas in which there is a crying need for action."

The McNamara bill provides for three distinct types of grants: (1) a direct grant of \$40,000 to each state for the necessary groundwork involved in the preparation of a state plan which must be approved before the state is eligible to receive further grants; the plan is to include an analysis of existing services for the aged, a survey of current needs, and a listing of proposed projects in

order of priority; (2) matching grants for demonstration projects made in accordance with the Hill-Burton formula with the Federal share ranging from one-third to two-thirds, depending on the per capita income of the state; (3) An additional \$2 million in the form of grants to public and other non-profit institutions and organizations for research and training programs.

The legislation calls for the creation of a new high-level position—an Assistant Secretary of Health, Education and Welfare for Aging—as well as an Advisory Committee and an Interdepartmental Committee on Aging. Senator McNamara called particular attention to the inclusion of the Declaration of Objectives for Senior Americans in the proposed bill: an adequate income, the best possible physical and mental health; suitable housing; full restorative services for those who require institutional care; equal opportunity to employment; retirement in health, honor and dignity; pursuit of meaningful activity; efficient community services which provide social assistance in a co-ordinated manner; immediate benefit from proven research knowledge; freedom, independence and free exercise of initiative.

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AWARDS

Four national agencies including the National Association for Mental Health honored Congressman Melvin R. Laird of Wisconsin recently for his outstanding efforts in support of important health service legislation.

Congressman Laird was also honored by the American Cancer Society, Research to Prevent Blindness, Inc., and the American Association of Medical Colleges. In the near future the same four organizations will present similar testimonial awards to

U. S. Senators Margaret Chase Smith of Maine and Lister Hill of Alabama and to Congressman John E. Fogarty of Rhode Island. The Senators are leading members of the Senate subcommittee on appropriations for health agencies; the congressmen are leading members of the House subcommittee on appropriations.

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PUBLIC INFORMATION

The Cleveland Health Museum has a new "Wonder of New Life" exhibit portraying the miracle of human reproduction. This exhibit is not limited to a portrayal of the so-called "facts of life" but includes for the first time such important subjects as heredity, mental health, the story of fertilization. The mental health part of the exhibition is called "preparing for the third child." Against the background of a life-size living room and nursery diorama members of a three-generation family simulate by sights, sounds and slides the emotional up's and down's experienced when expecting a new member of the family.

The opening of this new exhibition is part of the \$106,000 "new look" development program which calls for complete modernization of all Cleveland Health Museum exhibits.

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The National Association for Mental Health has presented an award to the Outdoor Advertising Association of America, Inc., "for an outstanding job in bringing the problem of mental illness to the attention of the American people."

The Outdoor Advertising Association is made up of many thousands of individual outdoor advertising companies throughout the country. This association has endorsed the public education campaigns of the

NAMH since 1956, encouraging its member firms to allocate free space for mental health posters. The number of posters displayed in roadside billboards has doubled since the first year of the program.

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APPOINTMENTS

The Minnesota Department of Public Welfare has announced the appointment of Dr. Herbert O. Dorken, consultant psychologist, to the post of director of community mental health services.

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Dr. Bernard C. Glueck, professor of psychiatry at the University of Minnesota, resigned effective July 15 to become director of research, Institute of Living, Hartford, Conn.

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MEETINGS

The Third World Congress of Psychiatry will be held in Montreal from June 4-10, 1961 under the auspices of the Canadian Psychiatric Association and McGill University. Copies of the "First Announcement" can be obtained by writing to the General Secretary, Third World Congress of Psychiatry, Allan Memorial Institute, 1025 Pine Avenue West, Montreal 2, P. Q., Canada.

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The scientific sessions of the mid-winter meeting of the Academy of Psychoanalysis will be held December 10 and 11, 1960, at the Hotel Biltmore in New York City. The theme of the first day's meeting will be "The Role of Values in the Psychoanalytic Process." The second day's meeting will be devoted to a series of papers by members

of The Academy. Inquiries may be addressed to Joseph H. Merin, M.D., Secretary, The Academy of Psychoanalysis, 125 East 65th Street, New York 21, N. Y.

President of the Academy for 1960-61 is Dr. Frances S. Arkin, one of the founders of the first psychoanalytic institute in this country to be connected with a medical school.

* * *

The Eighteenth Annual Reading Institute at Temple University will be held in Philadelphia January 23 through January 27, 1961. The theme will be "Reading Problems: Diagnosis and Treatment." Further information may be obtained by writing to The Reading Clinic, Department of Psychology, Temple University, Philadelphia 22, Pa.

* * *

The American Psychiatric Association will hold its Twelfth Mental Hospital Institute at the Hotel Utah in Salt Lake City October 17-20, 1960. The main theme will be "Needs of the Mentally Ill: Types of Effective Action Between the Community and Its Hospital Facilities." Enrollment forms may be obtained from the APA Mental Hospital Service, 1700 18th St. N. W., Washington 9, D. C.

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The Illinois Psychiatric Advisory Council and the Galesburg, Ill., State Research Hospital are holding a Tenth Anniversary Symposium on October 21-22, 1960, at the Hotel Custer in Galesburg. The symposium will deal with biological, psychological, and sociological research approaches to current psychiatric problems. For further information, write to: Thomas T. Toulentes, M.D., Superintendent, Galesburg State Research Hospital, Galesburg, Ill.

The World Federation for Mental Health held its thirteenth annual meeting in Edinburgh, Scotland, August 8 through August 13. On August 12 a trans-Atlantic conference of medical and psychiatric leaders in the United States and Canada was held via a trans-oceanic telephone hook-up. A panel of four doctors attending the Edinburgh meeting electronically joined a panel of Americans located at the Carnegie Endowment for Peace in New York City to discuss the particular problems of the aged.

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The American Psychosomatic Society will hold its eighteenth annual meeting at Chalfonte-Haddon Hall in Atlantic City, N. J., April 28-30, 1961. The Program Committee would like to receive titles and abstracts of papers for consideration for the program. Time allotted for presentation of each paper will be 20 minutes. The deadline for the submission of abstracts is December 1, 1960, and the abstracts should be not more than two typewritten pages in length. The Program Committee would like to receive nine copies of each abstract. These should be addressed to the Program Committee Chairman, American Psychosomatic Society, 265 Nassau Road, Roosevelt, New York.

* * *

The American Academy of Psychotherapists will hold its Fifth Annual Conference at the Hotel Carter in Cleveland on October 15 and 16, 1960. The title for this meeting is "Psychotherapy—Healing or Growth." There will be at least four panelists and a moderator, seated in the style of theater-in-the-round. The discussion is to be impromptu and no papers will be read. Chairman is Dr. O. Spurgeon English. For further information write to Dr. Bill J.

Barkley, Chairman, 1865 Coventry Road, Cleveland Heights 18, Ohio.

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Dr. E. Vincent Askey, president of the American Medical Association, will be the principal speaker at the Friday banquet highlighting the 1960 annual meeting of the National Association for Mental Health. The meeting will be held in Denver November 17-19, 1960. Dr. Askey recently said that he would like to dedicate himself during his year as AMA president "toward finding solutions to the problem of mental illness."

Dr. Francis J. Braceland, psychiatrist-in-chief of the Institute of Living in Hartford, Conn., will deliver a talk officially launching the 1960 convention on Thursday noon, November 17. Dr. James B. Austin, administrative vice president, research and technology, U. S. Steel Corporation, will speak at the Business and Industry Luncheon on Saturday.

The theme for the four-day meeting will be "A Decade of Progress" in observance of the tenth birthday of the NAMH.

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The Academy of Religion and Mental Health will hold its Fourth Academy Symposium at Arden House, Harriman, N. Y., November 18-20, 1960. The theme is "The Place of Value Systems in Medical Education." Attendance is by invitation only. The proceedings of these symposia are available in book form at cost through the offices of the Academy, 16 East 34th Street, New York 16, N. Y.

The Academy will hold its second annual meeting at the Hotel Biltmore in New York City January 18-20, 1961. Reservations may be made through the offices of the Academy.

An institute on the Rehabilitation of the Emotionally Disturbed was held at Boston University in June. The two-week institute included as participants top leaders in the field of mental health.

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The fifty-fifth annual meeting of the American Sociological Association was held at the Statler Hilton Hotel in New York City August 29-31, 1960. It brought together sociologists from all over the country for a program of 86 sessions designed to study the many facets of society with which sociology is concerned. A number of the more than 300 papers presented were focused on issues currently in the foreground of both international and domestic news.

Studies dealing with world problems took up various aspects of sociology applied to African culture and the effects of westernization; the place of science, population controls, status concept in Russia, China and other communist countries; mass media in Latin America; health social practices in Puerto Rico and planning and development in underdeveloped countries.

Reports on the domestic scene included sociological studies on politics, suburban voting trends, bias and attitudes; race relations, desegregation effects. Studies in industrial sociology presented analyses of leadership, conflicts, power structure in and between unions and management. Sessions on the Sociology of Deviation offered new insight on person and property offenders and types of sex offenders.

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PUBLICATIONS

Two new Joint Commission on Mental Illness and Health monographs have recently been published. *Americans View Their*

Mental Health, published by Basic Books, Inc., and written by Gerald Gurin, Joseph Veroff and Sheila Feld, is based on a nationwide interview survey conducted by a team of field investigators from the University of Michigan's Survey Research Center.

These investigators asked thousands of Americans representing a cross-section of the population questions concerning mental health. The study set out to examine two general categories. One is the way individuals feel they have adjusted to life, whether they think they are happy or unhappy, worried or unworried, the picture they have of themselves and their attitudes toward three important areas of their lives: marriage, parenthood and work. The second category deals with how people cope with problems; what motivates them to seek help; where they turn for it; how effective they think help has been; why some people fail to seek help and how they get along without it.

The second new Joint Commission monograph is entitled *Epidemiology and Mental Illness* published by Basic Books, Inc., and written by Richard J. Plunkett and John E. Gordon. This book reviews the history of epidemiological efforts in the field of mental health and discusses 11 surveys of mental illness in various communities.

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The National Association for Mental Health has published three catalogs of mental health materials for 1960-61. The *List of Mental Health Publications and Audio-Visual Aids* includes 12 new references this year. The *Catalog of Selected Publications About Mental Illness* and the *Special Listing of Mental Health Publications About Children and Adolescents* also include several new publications.

Of interest to many community groups and many individuals in the clinical professions is a new volume issued by the New York State Department of Mental Hygiene under the title *A Guide to Communities in the Establishing and Operation of Psychiatric Clinics*. The guide is based on the extended clinical and field consultant experience of the authors: Luther E. Woodward, Ph.D., and Winifred W. Arrington, M.S.S., mental health representatives in the Division of Community Services of the New York State Department of Mental Hygiene. The book may be ordered through the Division at 240 State Street, Albany, N. Y. Cost is \$2.00 per copy, prepaid and properly drawn checks must accompany all orders.

* * *

A 24-page booklet describing the history of the mental health movement in Maryland from 1797 to 1960 has been published by the Maryland Association for Mental Health. The new booklet, entitled "A Bell Must Ring," includes photographs and comparative budgets chronicling the progress of the movement. Free copies may be had upon request from the association at 2100 N. Charles St., Baltimore 18.

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A report intended to stimulate the medical and legal professions to review the concepts of confidentiality in the physician-patient relationship and to consider the extent of legal rights of privileged communication in psychiatric treatment has just been published by the Group for the Advancement of Psychiatry.

The 32-page report is titled *Confidentiality and Privileged Communication in the Practice of Psychiatry*. Copies may be obtained at 50 cents each from the Publications Office, Group for the Advancement of

Psychiatry, 104 East 25th Street, New York 10, N. Y.

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The proceedings of the First International Medical Conference on Mental Retardation have been published. The volume includes 800 pages and is profusely illustrated. Copies may be obtained, at \$12.50 each, on approval if desired, from Grune & Stratton, Inc., 381 Park Avenue South, New York 16, N. Y.

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The Office of Mental Health Education and Information of the New York State Department of Mental Hygiene has published a pamphlet about the School for the Mentally Retarded at West Seneca, N. Y. Complimentary copies may be ordered from the Office at 240 State Street, Albany, N. Y.

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The School of Home Economics of the University of Connecticut, Storrs, Conn., has published a new list of publications concerning teaching materials in the area of homemaker rehabilitation. Copies of this listing may be ordered from the School.

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A new booklet, *How to Deal With Mental Problems*, is replacing *How to Deal with Your Tensions* as the featured item in the newest phase of the Better Mental Health Campaign sponsored by The Advertising Council in behalf of the National Association for Mental Health. It is being offered free in single copies to individuals who request it in response to public service advertisements in newspapers, magazines and transit facilities and on television and radio.

How to Deal with Mental Problems was

written by NAMH public relations director Harry Milt.

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A report of the first Asian seminar on Mental Health and Family Life has been published. Entitled *Reality and Vision*, it was written by Dr. Tsung-Yi Lin. The seminar was held in Baguio, Philippines, in December, 1958. It was sponsored jointly by the Government of the Republic of the Philippines, The Asia Foundation, the World Federation of Mental Health and the World Health Organization.

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The American Psychiatric Association has published *A Descriptive Directory of Psychiatric Training in the United States and Canada, 1960*. This is the third edition of the directory published by the APA in 1953 and revised in 1955. In preparing this new edition the Committee on Medical Education of the APA decided that it would confine the content to information about training programs approved by the Council on Medical Education and Hospitals of the American Medical Association and by the Royal College of Physicians and Surgeons in Canada.

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A volume containing the scientific papers and discussions from the divisional meeting of the American Psychiatric Association in Detroit in October, 1959, has just been published. It is edited by Jacques S. Gottlieb, M.D. and Garfield Tourney, M.D. The editors state in their introduction that "this is the first of what is hoped will be a long series of publications of the proceedings of divisional meetings."

MISCELLANEOUS

The second "Operation Friendship" program designed to bring hundreds of thousands of visitors to the nation's mental hospitals was termed a "repeat success" this year with many hospitals reporting a 100 per cent increase in the number of visitors over 1959. The Friendship program was conducted during the first week of May, Mental Health Month.

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Conversion of the J. N. Adam Memorial Hospital in Perrysburg, N. Y., from a facility for the care of tuberculosis patients to one for the mentally retarded is now underway.

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The Jamaica, West Indies, Child Guidance Association has recently been organized. Its aim is to establish a Child Guidance Center. The Association is a voluntary one. It is under the patronage of Lady Blackburne, the wife of the Governor of Jamaica.

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Preliminary reports on the 1960 fund-raising campaign conducted by the National Association for Mental Health indicate slight increases throughout the country over 1959 with some areas reporting 10 to 20 per cent increases.

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A new national organization, The Family Institute, has been formed to combat and treat mental illness on a family rather than an individual basis. Its chairman is Dr. Nathan W. Ackerman, associate clinical professor of psychiatry at Columbia University. The new institute will have offices at 10 East 44th Street, New York City.

Donald G. Paterson, a pioneer psychologist, retired in June after 39 years of service to the University of Minnesota. Now professor emeritus of psychology, he was a pioneer in the whole advance of student personnel, vocational and industrial counseling. He is the founder and former president of the American Association of Applied Psychology and was secretary of the American Psychological Association for six years.

* * *

Mental disease is the top cause of physical disability retirements in the U. S. Navy and Air Force. This is revealed in a survey conducted with the help of Army, Navy and Air Force experts by the *Army Navy Air Force Journal*.

In the Army, mental disease ranks second to tuberculosis; heart disease is a close third. In the Navy and Air Force, tuberculosis ranks behind mental illness and heart trouble. The study reveals a sharp reduction in the number of disability retirements in the Army, Navy and Marine Corps, with a rise in such retirements among Air Force personnel.

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The American Contract Bridge League has selected the National Association for Mental Health as the beneficiary of its 1960-61 charity program. The ACBL has pledged to raise at least \$150,000 for the new Research Foundation of the National Association for Mental Health.

Each year the ACBL Board of Directors selects an official League beneficiary. Last year the American Red Cross Disaster Fund received over \$161,000 from the charity program. Throughout the year 3,000 affiliated League clubs in the United States, Canada, Mexico and overseas raise funds for the selected beneficiary through special duplicate

games and tournaments. All card fees are contributed to the charity program.

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ARTICLES SCHEDULED FOR PUBLICATION IN COMING ISSUES OF MENTAL HYGIENE

- "Criteria for Involuntary Hospitalization of Psychiatric Patients in a Public Psychiatric Hospital" by Silas L. Warner.
- "What Is a Halfway House? Functions and Types" by Brete Huseth.
- "The Main Themes of Existentialism from the Viewpoint of a Psychotherapist" by Leif J. Braaten.
- "Psychology, Psychiatry and Mental Illness in the Mass Media: A Study of Trends, 1900-1959" by George Gerbner.
- "The Three Worlds of the Back Ward" by Olive M. Stone.
- "Recreational Preferences as Predictors of Participation in Mental Hospital Activities" by William E. Morris and Milton B. Jensen.
- "Meeting the Problems of Intake in Child Guidance and Marital Counseling" by Ruth C. Oakey.
- "An Open Service in a University Psychiatric Clinic" by Sally Dewees, Ruth F. Johnson, Saxton T. Pope and Mary A. Sarvis.
- "Improving Poor Work Adjustment through Psychodiagnostic Evaluation" by Paula C. Oken and Alfred L. Brophy.
- "Service Attitudes of Board and Staff Members of Community Mental Health Clinics" by Daniel N. Wiener and Allan A. Hovda.
- "A Survey of Employer Reactions to Known Former Mental Patients Working in Their Firms" by Reuben J. Margolin.
- "The Value of Supervision in Training Psychiatrists for Mental Health Consultation" by Beulah Parker.
- "Status Stress and Role Contradictions: Emergent Professionalization in Psychiatric Hospitals" by William R. Rosengren.
- "Transitional Residences for Former Mental Patients: A Survey of Halfway Houses and Related Rehabilitation Facilities" by Henry Wechsler.
- "Psychiatric Care in Transition" by D. G. McKerracher.
- "Love as a Measure of Man" by Benjamin Mehlman.
- "The Psychology of Democratic Freedom" by Joost A. M. Meerloo.
- "The Prevention of Mental Illness" by Donald C. Klein.
- "Mental Health and Group Dynamics for Discussion Leaders in Mental Health Programs" by Dell Lebo.
- "Hospital-Patient Relationships in Medicine and Psychiatry" by Thomas S. Szasz.
- "A Survey of Vocational Rehabilitation at Longview State Hospital for 1959" by Harvey E. Wolfe.
- "The Reintegration of the Chronic Schizophrenic Patient Discharged to his Family and Community as Perceived by the Family" by Eva Deykin.
- "The Effects of an Activity Program on Chronic Psychotic Patients" by Margaret E. Hitt.
- "Personality Disorganization Camouflaged by Physical Handicap" by Lester A. Gelb.
- "A Telephone Interview: A Method for Conducting a Follow-up Study" by Catherine T. Bennett.
- "An Echo in Education" by Norma Parent.
- "On the Unity of Religion and Psychiatry" by Joseph H. Golner.
- "Pattern of Discharge and Readmission in Psychiatric Hospitals in Norway, 1926-1955" by Ørnulf Ødegaard.
- "Permissiveness and Morality" by Jules Henry.
- "Children in Crisis" by Warren T. Vaughan, Jr.
- "The Personal Problems of College Students" by Ralph M. Rust and James S. Davie.
- "The Volunteer in Psychiatric Rehabilitation" by Winfred Overholser.
- "Situational Factors Contributing to Mental Illness in the United States: A Theoretical Summary" by John Arsenian.

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